MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Page 4 may be retained by the husering an enterving progression.

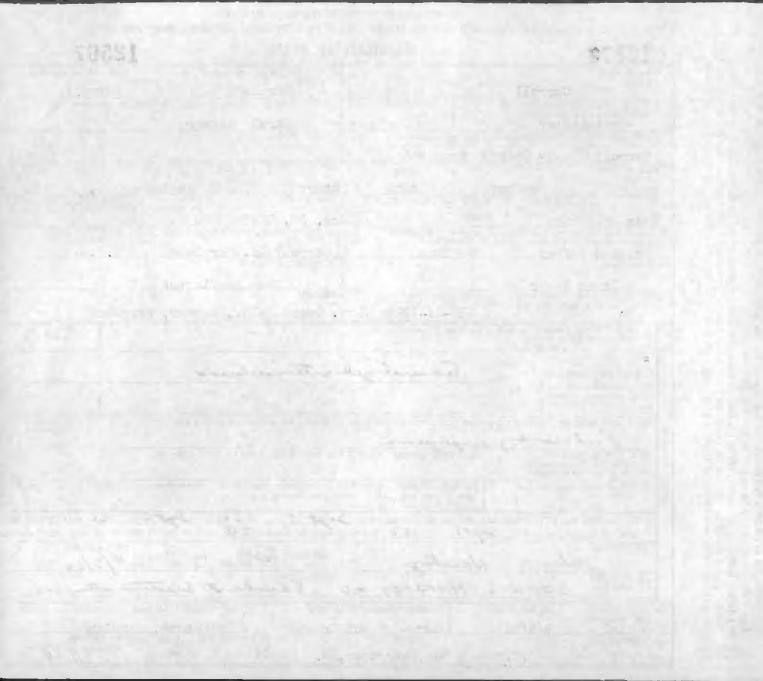
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and campletely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remarve carban papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, crematian, or removal, and in any event, within 72 haurs after death. TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 haurs after death. Page 4 may be retained by the haspital ar attending physician.

CERTIFICATE OF DEATH

12567

3.4		July 20 0 24							2.00	-	
1		PLACE OF DEATH D. COUNTY	Carroll		MAR	YLAND	2. USUAL RESIDENCE (o. STATE Mary.		b. COUNTY	ce before odmiss	ion)
	b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest fown) Westminster				C CITY OR TOWN (If outside corporate limits, write RURAL ond give neorest town) Rural Keymar						
	d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)					d. STREET ADDRESS			e. IS RES ON A	FARM?	
	Carroll County General Hospital								YES 😾		
	D	NAME OF DECEASED Type or point)	Sydr	rs1 ley	Middle Grant		Baker		O COUNTY OF THE	5. 19	66_
	5. 5	SEX 6.	COLOR OR RACE	7. MARRIED	NEVER MARRIE	D D B	B. DATE OF BIRTH	9. AGE (In y		YEAR IF UNDER	R 24 HRS.
	1	Male W	hite	WIDOWED	DIVORCE		ct. 20, 188	35 80	Yrs.		
	10o.	USUAL OCCUPATION (Ging most of working life,	ive kind of work done	10b. Kil	ND OF BUSINESS OR		11. BIRTHPLACE (County & State, or foreign country) 12. CITIZEN OF WHAT COUNTRY?				
	QUIII	Retired F	armer		farm			. Maryland		5. A.	
	13.	FATHER'S NAME					14. MOTHER'S MAIDEN	NAME			
1		James	Baker					Penningto			
1	15. (Yes	WAS DECEASED EVER IN	U.S. ARMED FORCES? ves give wor or dotes	of service) 16. S	OCIAL SECURITY NO.		NFORMANT		Address		
	(100	s, no, or unknown) (If	11-3	218	3-24-1291	Mrs	. Grant Ba	ker, Keymar	, Maryla	4	
		18. CAUSE OF DEATH	H (Enter only one co	use per line for	(o), (b), ond (c).)					ONSET AND	
		IMMEDIATE CAUSE (o)									
		Conditions, if ony, which gove) (b) Generally anteriosclerasis									
	rise to immediate couse (a).										
		stating the underlyi	ng couse	(c)							
	PART II, OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL						HE TERMINAL DISEASE CO	NDITION GIVEN IN PART	1(0)	19. WAS AU	TOPSY MED?
	Bulmonny emphysewa								YES _	NO -	
	Gulmonary employeem 200. ACCIDENT WAS UNDERLYING OR CONTRIBUTING OR CON							Port I or Port II of item	18.)		
	MEDICAL	20c. TIME OF INJURY Hour o.m.		20d. IN While of work	JURY OCCURRED Not White at work		E OF INJURY (Home, forr ory, street, office bldg., etc.		own) (Cou	inty)	(Stote)
		21. I certify that (1) (this haspital) attended the deceased fram Left 5, 1966, to Sept 6, 1966, that (1) (we) last saw the deceased alive an Sept 6, 1966, and that death accurred at 215 M, fram causes and an the date stated above.									
		220 SIGNATURE	olu S.	Har	shey	M.D	ATTENDING PHYS.	MED. STAF	FUR	STE SIGNED	
		22c. PHYSICIAN'S NAME (Type)	SOHN	5. 14	ARS HEY	, M.D	22d. ADDRESS	horst We	strum	ten, w	4
	230	BURIAL, CREMATION,	23b. DATE TH	IEREOF	23c. NAME OF CEN	NETERY OR	CREMATORY	23d. LOCATION (Cit	y or Town)	(County)	(Stote)
		REMOVAL (Specify) Burisl	9/9/66	5	Church of	God	Cemetery	Uniontow	n, Maryl	and	
	24	FUNERAL DIRECTOR	1.1.		ADDRESS		250. REC	P REGISTRAR 1966	256. REGISTRAR'S S	Ces Jud	el
	1	mult sh	ulla C.O.	russ &	Son, Taney	rtown.	Md. DATE St	0 1000		0 0	the last

VR A15 (4)



PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) WAS AUTOPSY 19. PERFORMED? NO X YES [20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part 1 or Part II of Item 18.) (County) (State) M. from the causes and on the date stated above. 22b. DATE SIGNED 23d. LOCATION (City, town or county) Littlestown, Adams Co. 25a. REC'D BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE ADDRESS FUNERAL DIRECTOR DATE S Littlestown, Pa 100

Carroll

e. IS RESIDENCE

Year

1966

Pa_

NTERVAL BETWEEN

ONSET AND DEATH

YES

Day

12. CITIZEN OF WHAT

.S.A.

ON A FARM?

NO *

VR A15 (4) 20M 1/65 the state of the s

trochidac (Lorus androck minimum) plants

Talking weaking from the analysis of the analy

The state of the second of the

SE PROMINE A SALE SALE

Life wifer a cut maper uses (seeing) the seein words, but we are

programme to state the second second

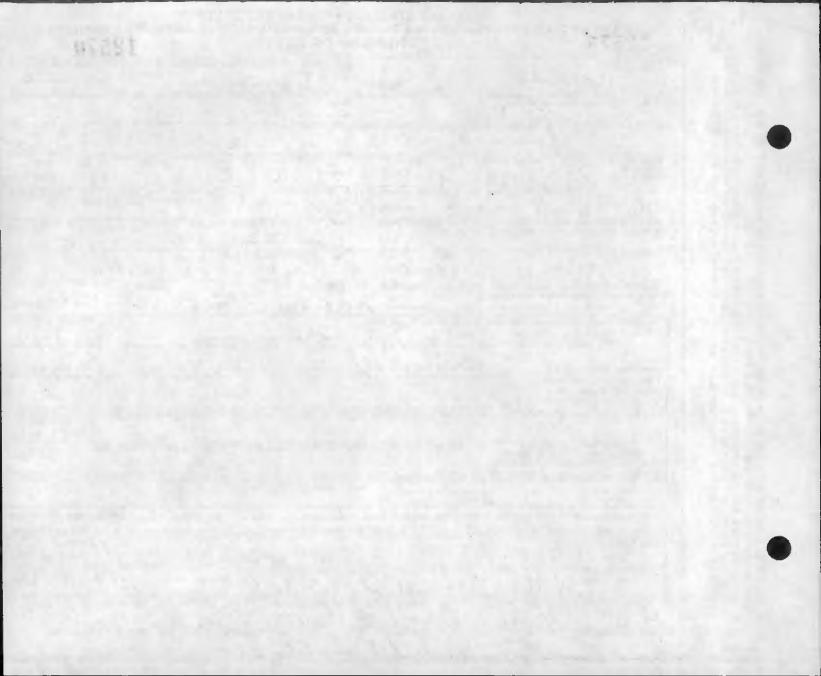
. dept. investigate vanished terms on the beauty to be

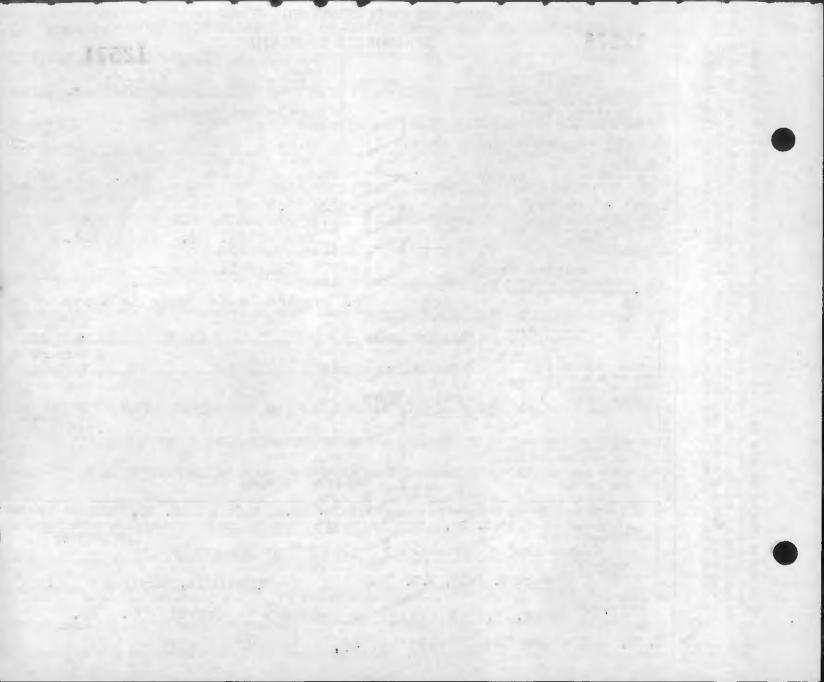
The State of the s

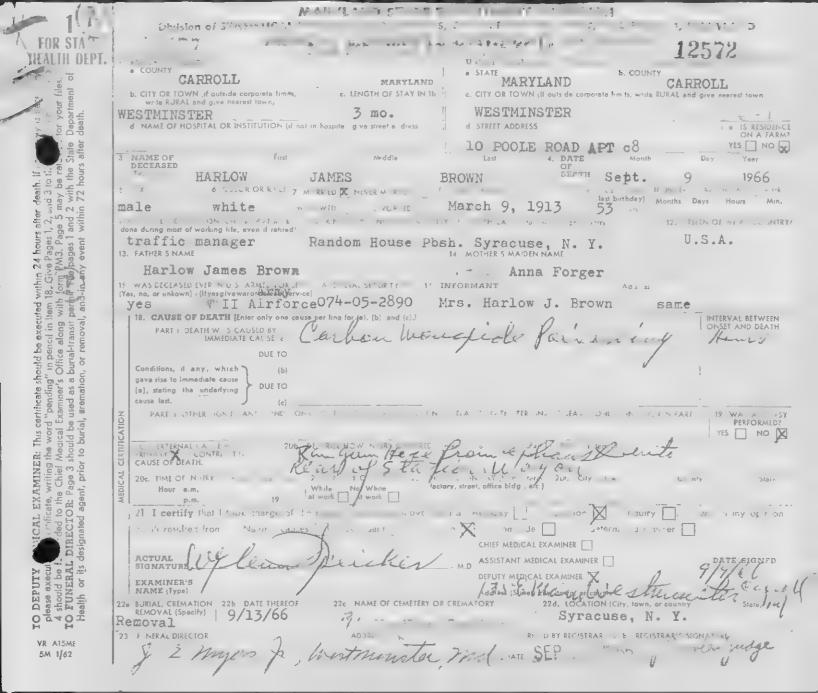
1	MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
= = 22	CERTIFICATE OF DEATH 12569
death death	1. PLACE OF DEATH a. COUNTY (ARROll MARYLAND 2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission a. STATE Md. b. COUNTY (ARROll MARYLAND
aft th ges aft	b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town write RURAL and give nearest town) c. LENGTH OF STAY IN 1b c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
nour in S. I	RUIA - Woodbine Life NOTAL OR INSTITUTION (If not in hospital, give street address) d. STREET ADDRESS ON A FARM?
24 fille pape in 72	SAMS Creek ROAD SAMS Creek ROAD YES NO NO
executed within and completely remove carbon I and event, with	3. NAME DF DECEASED (Type or print) MYTA LARUE BIDINGER DEATH SEPT. 17, 1966
e executed will an and complete in any event,	5. SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED 8. OATH OF BIRTH 9. AGE (In years IFUNDER 1 YEAR IFUNDER 24 HR
exec n and rem in an	102. USUAL OCCUPATION (Give kind of work done 105. KIND OF BUSINESS OR 11. BIRTHPLACE (County & State, or foreign country) 12. CITIZEN OF WHAT
nd se	during most of working life, even if retired) 212-240BG; MARY land COUNTRY?
certificate nding physi . Then ple removal, a	Stephen Cartrell (FACO Hingling
_ e.±.5	15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT Address (Yes, no, pr unkdown) ((If yes give war or dates of service)
9 a a a	No 2/2-22-29/1/1/R. CHARENCE, BIDINGER - Wood DINE, Md 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] INTERVAL BETWEEN
Z > Z	PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerosis, generalized; July, 196
ysicial that the signed rial t	Conditions, If any, which) DUE TO through Conditions, If any, which) (b) Caronary thrombosis with immediate cardiac 9/17/66
OR ATTENDING PHYSICIAN: The law requires that the les retained by the hospital or attending physician. IRECTOR: After this certificate has been signed by the 3 should be detached for use as the burial-transit with the State Dept. of Health prior to burial, cremain	gave rise to immediate cardiac bus to arrest.
law rec attendin has be as th prior t	underlying cause last.) (c) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS AUTOPSY
The lor a icate or use lealth	PERFORMED? YES NO
PHYSICIAN: The tarthe hospital or attractions the detached for use a te Dept. of Health	PERFORMED? YES NO 20a. ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury In Part 1 or Part II of Item 18.) OR CONTRIBUTING CAUSE OF DEATH OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
PHYSI the ha this detacl	20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, 20f. (City or town) (State)
DING PP ed by th After t d be de e State	
ATTENDING retained by ECTOR. After 3 should be with the State	21. I certify that (I) (this hospital) attended the deceased from July , 19 66 to Sept. 17, 19 66, that (I) (we) las saw the deceased alive on Sept. 17, 19 66, and that death occurred at 3:30 M, from the causes and on the date stated above
DIREC	22a. SIGNATURE 22b. DATE SIGNED M.D. ATTENDING X DIRECTOR PHYS. Sept. 19, 1966
TO HOSPITAL OR ATTENI Page 4 may be retaine TO FUNERAL DIRECTOR. director, page 3 should be filed with the	22c. PHYSICIAN'S NAME (Type) HOWARD E. HALL MD. 22d. ADDRESS SUKESVILLE Md.
Page Page O FUN direct	23a. BURIAL, CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City, town or county) (State)
- = R	24. FUNERAU DIRECTOR ADDRESS ADDRESS 25aREC'D BY REGISTRAR' 25b. REGISTRAR'S SIGNATURE
VR A15 (4)	Harry W. Haight Sykisville, That. DATE SEP 22 1966 gelianles Judg
2011 1/00	



-	1 (PARTMENT OF HEALTH	
S San	. (M)	DIVISION OF STATISTICAL RESEARCH AND RECORDS		, MARYLAND
草	世で達し	-	2201	16	2048
dea	and 2 death	1.	PLACE OF DEATH	2. USUAL RESIDENCE (Where deceased lived, If Institution a. STATE b. COUNTY	n: Residence before admission
after death	the fes 1 after		Carroll	Maryland	Carroll
4	s af		o. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	c. CITY OR TOWN (If Jutside corporate limits, write RU	RAL and give nearest town;
hours	in by Pag tours		manchester Md	MANCHESTON	08-1
			d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)	d. STREET ADDRESS	e. IS RESIDENCE ON A FARM?
72	filled papers in 72			108 your 31	YES ND
The law requires that the death certificate be executed within or attending physician.	carbon p	3.	NAME DF First Middle	G Last G. DATE Month	Day Year
× ×	comple γe carb event,		Type or print) / MAUTICE M.	1) 1/1 C/C DEATH LEVY	19 1966
uted	2 8 5	5.	SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED	8. DATE OF BIRTH 9. AGE (In Years IF UNI last birthday) Month	DER 1 YEAR IF UNDER 24 HRS
Xec	and		Tale White WIDOWED DIVORCED	Nov25-1408 57 yrs.	
0	三気造	1Da dur	USUAL OCCUPATION (Give kind of work done 10b, KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country) 12	2. CITIZEN OF WHAT
e 2	rsicia leas and			Carriel Co . M.C.	WSIT
cat	physi n ple val, a	13.	FATHER'S NAME	14. MOTHER'S MAIDEN NAME	11
芸	iding ph Then remova		Claylor M. 13/1/CR	10 PrthA M. Mil	1 ("
Ş.	E == =	15. (Ye	WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17.	INFORMANT	1 1
eat			MI	rs MAURICE BLACK, MAN	vchester, mo
9	± ± 50		18. CAUSE DF DEATH [Enter only one cause per line for (a), (b), and (c).]	2/ 0	INTERVAL BETWEEN ONSET AND DEATH
## ##	transi crem	Ш	PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	Lhrombous	IOMINI
PHYSICIAN: The law requires that the hospital or attending physician.	gned ial-tra ial, cr	П	DUE TO C. +	+ 1	-
res	purial burial burial		Conditions, If any, which gave rise to Immediate (b)	robe Cardio Viralan	o syrs
in a	been the b		cause (a), stating the DUE TO	Percuse	0
W F	has t as t prior	2	underlying cause last.) (c)		Man HITODAY
- 	ficate has bo for use as the	TIO	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELA	ATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1	1(a) 19. WAS AUTOPSY PERFORMED?
E 5	ficat ficat for u Heal	FICA			YES NO
A STIC	certificate ned for use to Health	CERTIFICATION	20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	URRED. (Enter nature of injury in Part I or Part II of Item	18.)
SIC	this cer etached Dept. o			AND	(01010)
PHY	this detac	MEDICAL	2Dc. TIME DF INJURY Month, Day, Year 2Dd. INJURY OCCURRED 20e. PLA Hour a.m. While Not While	ACE OF INJURY (Home, farm, 20f. (City or town) ory, street, office bidg., etc.)	(County) (State)
# 2 A	tter Stat	ME	p.m. 19 at work at work		
ATTENDIN retained b	700		21. I certify that (I) (this hospital) attended the deceased from		9 <u>66</u> , that (1) (we) las
High	ECTOR: 13 should with the			t death occurred at 100 M, from the causes and o	
98			220. SIGNATURE. 1 7	ATTENDING MED. STAFF	DATE SIGNED
34 %	page filed		22c. PHYSICIAN'S	D. PHYS. DIRECTOR PHYS. 22d. ADDRESS	11100
TO HOSPITAL Page 4 may	O FUNERAL director, pa should be f		NAME (Type) W. It TO Ard M. D	MANCHESTER	1021102
HOS	FUN	23a	BURIAL, CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERY	Y OR CREMATORY/ 23d LOCATION (City, town or	county) (State)
2	5 9 %		STEMOVAL (Specify) 9/23/66 Manchosters	Same they Manchestry	2d word 6
	00	24	FUNERAL DIRECTOR ADDRESS /	25a REC'D BY REGISTRAR 25b. REGIST	RAR'S SIGNATURE
	A15 (4)	1/	and Il Kennya The 260 Zarlan & It Ho	anover la DATE SEP 2 3 1966 OCL	confor Julas
15	M 4-64	1	man I sermand voldingen to the	7 1 100	Judge









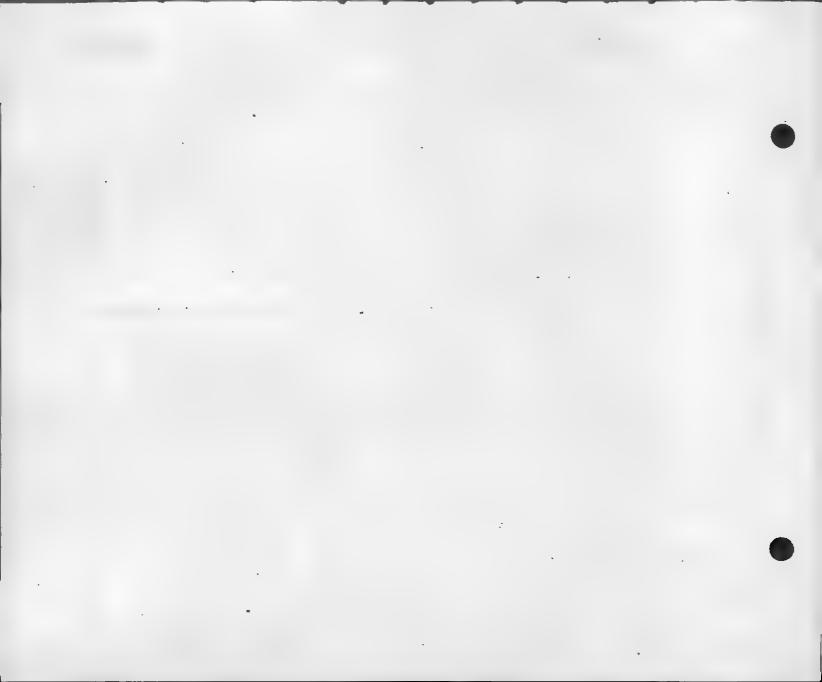
MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH 24 haurs after death PLACE OF DEATH 2 USUAL RESIDENCE (Where deceased lived if institution. Residence before admission) COUNTY CQUNTY Carroll hages I auri MARYLAND Baltimore City C LENGTH OF STAY IN 10 c CITY OR TOWN (if outside corporate imits, write RURA), and give nearest towns b CITY OR TOWN (if outside corporate I mits, campletely filed in by the ave carban papers. Page y event, within 72 haurs af write RURAL and give nearest town)
Sykosville lvr. 3mos. Baltimore a NAME OF HOSPITAL OR INSTITUTION (If not in hospital a ve street address) d STREET ADDRESS e IS RESIDENCE ON A FARM? 113 N. Bond St. Springfield State Hospital YES NO X executed within and campletely fi remave carban p 3 NAME OF Midd e 4 DATE Month DECEASED OF 66 LEWIS HENRY CANNON SEPTEMBER 27 19 (Type or print) DEATH B DATE OF BRTH F UNDER 24 HRS S SEX 6 COLOR OR RACE AGE In years 7 MARRIED NEVER MARRIED last birthdoy) Hours 2-8-38 Male Negro attending physic an and co permit. Their please rema-ian, ar removal, and in any WIDOWED DIVORCED 100 S. AL OCC JPATION (Give kind of work done 12 C 7 ZEN OF WHAT 10b KIND OF BLS-NESS OR 1 B RTHPLACE (County & State or foreign country) during most of working life, even if retired) COUNTRY? INDUSTRY North Carolina that the death certificate 13 FATHER , NAME 14 MOTHER S MA DEN NAME Wright Cannon Frances Longs 15. WAS DECEASED EVER IN J.S. ARMED FORCES? 16 SOCIAL SECURITY NO 17 INFORMANT ādrīress. (Yes, no or unknown) ((If yes give war or dates of service) Records, Springfield State Hospital None crematian, 18 CAUSE OF DEATH (Enter only one couse per ne for (o) (b), and (c)) NTERVAL BETWEEN signed by the burial-transit p burial, cremati the OWSET AND DEATH PART I DEATH WAS CAUSED BY IMMEDIATE (AUSE (a) Far advanced pulmonary tuberculosis, active DUE TO Conditions, if only which gove nse to immediate couse (o), DUE TO stating the underlying couse by the haspital or attending TO FUNERAL DIRECTOR: After this certificate has been directar, page 3 should be detached for use as the shauld be filed with the State Dept. of Health prior to PART II OTHER SIGNIFICANT CONDITIONS CONTRIBLING TO DEATH BUT NOT RELATED TO THE TERMINA DISEASE CONDITION GIVEN IN PART 1(g) CBS with convulsive disorder, without qualifying phrase. Mental deficiency, idiopathic, moderate. 19 WAS AUTOPSY PERFORMED? NO TX YES [200 ACCIDENT WAS UNDERLYING [3] 205 DESCRIBE HOW INJURY OCCURRED (Enter noture of injury in Port I or Port II of item 18.) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER MEDICAL 20d INJURY OCCURRED 20e PLACE OF INJURY (Home, farm, (City or town) (Stote) 20c TIME OF INJURY Month, Day, Year (County) Hour om. foctory, street, office bldg , etc.) Not While ATTENDING at work at work 21. I certify that (I) (this haspital) attended the deceased from ____, that (1) (we) last PM, fram causes and an the date stated above. Page 4 may be retained saw the deceased alive on 9-27-66 19 and that death accurred at 22b DATE SIGNED 220 SIGNATURE ATTENDING DIRECTOR 22d ADDRESS Springfield State Hospital 22 PHYSICIAN'S NAME (Type) Julian Radzykewycz, M. Sykesville, Maryland NAME OF CEMETERY OR CREMATORY 23d, _OCATION-(City or Town) BURIAL CREMATION (State) REMOVAL (Specify) 250 RECD BY REGISTRAR 25b REGISTRAR S SIGNATURE FUNERAL DIRECTOR VR A15 (4) 20 M 1/66



DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1. MARYLAND CERTIFICATE OF DEATH hours after death. PLACE OF DEATH USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. CDUNTY b. COUNTY MARYLAND papers, Page 72 hours a b. CITY DR TOWN (if outside corporate limits. C. LENGTH OF STAY IN 1b c. CITY OR TOWN (If ourside corporate limits, write RURAL and give nearest town) write RURAL and give nearest town) e. IS RESIDENCE d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) ON A FARM? NO X letely carbon NAME OF Middle DATE DF Month DECEASED event, and obmple remove car (Type or print) DEATH 19 7 executed AGE (In years | IF UNDER 1 YEAR | IF UNDER 24 HRS | last birthday) | Months | Oays | Hours | Min. COLOR OR RACE OATE OF BIRTH 7. MARRIED 5 NEVER MARRIED lease removing any e WIDOWED OLYGRCED the attending physicial sit permit. Then please re nation, or removal, and in a 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 12. CITIZEN OF WHAT 10b. KIND DF BUSINESS DR 11. BIRTHPLACE (County & State, or foreign country) **COUNTRY?** INDUSTRY abover certificate 13. FATHER'S NAME Marv George R. Chapman 15. WAS OECEASED EVER IN U.S. ARMED FORCES? 17. INFORMANT Address 16. SDCIAL SECURITY ND. cremation, or (Yes, no, or Unkown) | (If yes give war or dates of service) death INTERVAL BETWEEN been signed by the the burial-transit por to burial, cremati 18. CAUSE OF DEATH [Enter only one cause per line for ONSET AND DEATH PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) OUE TO Cenditions, If any, which (b) gave rise to immediate DUE TO cause (a), stating has be as th prior underlying cause last. WAS AUTOPSY PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. for use Health p PERFORMED? certificate ND 🔀 YES 2Da. ACCIDENT WAS UNDERLYING [OESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury In Part 1 or Part II of Item 18.) detached detached to Dept. of OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) MEDICAL 2Dd. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, 20f. (City or town) (County) (State) 20c. TIME DE INJURY Month, Day, Year factory, street, office bldg., etc.) be de State Hour a.m. OIRECTOR: After age 3 should be dilled with the State Not While 19 at work p.m. at work retained 21. I certify that (I) (this hospital) attended the deceased from and that death occurred at \$ - EM, from the causes and on the date stated above. saw the deceased alive on 🗝 🥝 DATE SIGNEO 22a. SIGNATURE be de ATTENDING PHYS. director, page should be filed **OIRECTOR** PHYS. M.O. HOSPITAL FUNERAL 22d. AD OR ESS PHYSICIAN'S NAME (Type) BURIAL, CREMATION, NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City, town or county) (State) 23b. DATE THEREDE 23c. 2 REMOVAL (Specify) 9 -66 Burial FUNERAL OIRECTOR Liberty Hghts. Avenue ATE

MARYLAND STATE DEPARTMENT OF HEALTH

VR AI5 (4) 2DM



RYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH should 2. USUAL RESIDENCE (Where deceased lived, If institution) has dence before edmission) 1. PLACE OF DEATH e. COUNTY b. COUNTY -MARYLAND Sallyme b. CITY OR TOWN if outside corporele limits. CITY OR TOWN (If outs de corporete I m is write RURAL end give nearest town c. LENGTH OF STAY IN 16 write RURAL and give nearest town? A NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES NO V NAME OF Middle paper 75 DECEASED OF comple [Type or print] DEATH 1966 carbon with 5. SEX 6. COLOR OR RACE 8. DATE OF BIRTH AGE I'm years LIF UNDER I YEAR ! IF UNDER 24 HRS. 7. MARRIED MI NEVER MARRIED last birthday) Months Deys HE Tyrs. WIDOWED [DIVORCED physician USUAL OCCUPATION (Give kind of work 12 CITIZEN OF WHAT COUNTRY? 10b. KIND OF BUSINESS OR NDUSTRY done during most of working life, even if retired) 13. FATHER'S NAME MOTHER'S MAIDEN NAM ğ ā 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO 17 INFORMANT Ad dress (Yes, no, or unknwn) | (Ifyesgive wer or detes of service) INTERVAL BETWEEN 18. CAUSE OF DEATH [Enter only one cause per line for tal !b ONSET AND DEATH PART I. DEATH WAS CAUSED BY: .MMEDIATE CAUSE (a) DUE TO Conditions, if env. which gave rise to immediate cause **DUE TO** (a), steting the underlying cause last. PART II. OTHER SIGNIF CANT CONDITIONS CONTROLLING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 16:119. WAS AUTOPSY CERTIFICATION PERFORMED? NO D 20b DESCRIBE HOW INJURY OCCURED (Enter neture of injury in Ped 1 or Pert 11 of Item 18.) 200. ACCIDENT WAS UNDERLYING OR CONTRIBUTING THE CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20d. INJURY OCCURRED 20m PLACE OF INJURY (Home, ferm, 20f. [City or town) 20c. TIME OF INJURY Month Day Year (County) (State) fectory, street office bldg etc. While Not While Hour e.m -st-work --21. I certify that (I) (this hospital) atlended the deceased from 1946, to 20/1/17 , 1960, that (1) (we) last and that death occurred at 20 M, from the causes and on the date stated above saw the tdeceased alive on 22b. DATE 220. SIGNATURE SIGNE STAFF DIRECTOR PHYS. M.D. FUNERAL rector, page filed with th 22d. ADDRESS PHYSICIAN NAME (TYPE 236. DATE THEREOF 238 MIRIAL CREMATION, NAME OF CEMETERY OR CREMATORY LOGATION (City, lowner county) / (Stete) dir. 0 256, REGISTRAR'S SIGNATURE FUNERAL DIRECTO VR A15 (4) 15M 7 62



1 (1/1)	DIVISION OF STATISTICAL RESEARCH AND	D RECORDS, 301 W. PRESTON STREE	I H ET, BALTIMORE 1, MARYLAND
# 1524 # 1524		TIFICATE OF DEATH	12576
death funera and death	ACE DE DEATH		ceased lived, If institution: Residence before admission)
Marin	COUNTY	MARYLAND a. STATE	b.,COUNTY
after y the ges 1 s after	CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		rporate limits, write RURAL and give nearest town)
nours of in by s. Page hours	La to had	no. Te antimole	smel RUHY
24 filled	NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give	street address) d. STREET ADDRESS	e. IS RESIDENCE ON A FARM? YES NO
within pletely arbon at, with	ME OF CEASED Pro or print)	idle Last 4. DATE OF DEAT	Month Day Year
comple ve carl event,	X 6. CDLOR OR RACE 7. MARRIED NEVER M	MARRIED 8. DATE OF BIRTH 9.	
executed and com remove c	WIDOWED D	IVORGED [last birthday) Months Days Hours Min.
be (cian sase and in	WAL DCCUPATION (Give kind of work done 10b. KIND DF BUSIN most of working life, even if retired) INDUSTRY	NESS OR 11. BIRTHPLACE (County & Statu	c, or foreign country) 12. CITIZEN OF WHAT COUNTRY?
#/ #=-	ATHER'S NAME	14. MOTHER'S MAIDEN NAME	, , ,
ding by Then remova	enes H Llours	Voice: for	in to addi
atter after rmit. n, or	AS DECEASED EVER IN U.S. ARMED FORCES? o, or unknown) (If yes give war or dates of service) 2 2 1 - 6 -	RITYND. 17. INFORMANT - 2283 Ealth Cond.	Address Fine Rand)
the by th nsit emat	PART I. DEATH WAS CAUSED BY:), and (c). 1	INTERVAL BETWEEN ONSET AND DEATH
res that physician signed burial-tra burial, cr	IMMEDIATE CAUSE (a)	in the state of	
phys sig surice ourie	inditions, If any, which (b) (falsa-ut	where Cordin Voscula al	e-leit .
라는 음 등 다	we rise to immediate use (a), stating the DUE TO	4.1 (- 1.7	
aw re ttendi has b as th as th prior	derlying cause last. (c) /41//	it the lettrike	,
	RY II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEAT	THBUT NOT RELATED TO THE TERMINAL DISEASE CON	IDITION GIVEN IN PART 1(a) 19. WAS AUTOPSY PERFORMED? YES NO
Spit Spit Sert Sert Sert Sert Sert Sert Sert Ser	a. ACCIDENT WAS UNDERLYING ☐ 20b. DESCRIBE HO CONTRIBUTING ☐ CAUSE OF DEATH FEITHER, NOTIFY MEDICAL EXAMINER)	W INJURY OCCURRED. (Enter nature of injury in P	art I or Part II of Item 18.)
the this deta	Hour am. While Not Whi	le factory, street, office bldg., etc.)	(City or town) (County) (State)
A THE STATE OF THE	p.m. 19 at work at work		12 tine 23, 1966, that (1) (we) last
ATTEND retained CTOR: / should vith the	21. I certify that (I) (this hospital) attended the dece		om the causes and on the date stated above.
ATT retraction and a state of the with	a. SIGNATURE	/.'	22b. DATE SIGNED
OR ATTENE y be retaine DIRECTOR: age 3 should	- Tarfol El Quel	M.D. ATTENDING MED.	□ STAFF PHYS. □ 9/23/66
PITAL 4 ma ERAL or, p	NAME (Type) USE DUSH	NID 22d. ADDRESS	EAD Maylond
Page Page FUN direct should	HURIAL CREMATION, 236. DATE THEREOF 23c NAM	E OF CEMETERY OR CREMATORY 23d. L	OCATION (City, town or county) (State)
5 5 5 5 X	urual 9/26/66 Loud	ton Park Corneting 10	satimure mid .
4	UNERAL DIRECTOR ADDR	ESS 25a. REC'D BY REGI	STRAR 25b. REGISTRAR'S SIGNATURE
VR A15 (4)	5.2. Myero - p. , lossimins	de Mare SEP : 7	1000 - 1-02



MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) 1 PLACE OF DEATH a COUNTY Carroll **b** COUNTY MARYLAND Maryland b CITY OR TOWN (f outside corporate limits CLENGTH OF STAY N Ib c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town). write RURA, and give nearest fown) (Rural) Sykesville 11y 5m Baltimore City e IS RESIDENCE ON A FARM? d NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) d STREET ADDRESS YES NO Springfield State Hospital 639 30th. Midd e 4 DATE Manth Day Year 3. NAME OF DECEASED Jack McCain 20 66 Curran 19 (Type or print) IF JNDER 1 YEAR IF UNDER 24 HRS 8 DATE OF BIRTH *SE In years 6 COLOR OR RACE 7 MARRIED [S SEX NEVER MARRIED st birthday) Months white WIDOWED 3 DIVORCED 10-10-86 male 12 CTIZEN OF WHAT 11 B RTHPLACE (County & State or for a country) permit. Then please relien, or removely and 10a .SUAL CCCUPATION (Give kind of work done 10b KIND OF BUSINESS OR COUNTRY? during me tof working! te even if ret red! Watchman -INDUSTRY -Consolikated-incireering Maryland, Baltimore USA 14 MOTHER'S MAIDEN NAME 13 FATHER'S NAME William Curran Margaret Thompson 'S WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, na. ar unknown)
(If yes give war or dates of service)
unknown 16 SOCIAL SECURITY NO 17 INFORMANT Address 212-12-0527 Hospital Records INTERVAL BETWEEN 18 CAUSE OF DEATH (Enter any one cause per line for (a) (b) and (c).) ONSET AND DEATH PART DEATH WAS CAUSED BY Far advanced tuberculosis IMMED ATE CAUSE (0) DUE TO Canditions, if any, which gave nse to immediate cause (a), DUE TO stating the underlying couse Arteriosclerotic heart disease years PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19 WAS AUTOPSY PERFORMED? YES SC Involutional Psychotic Reaction NO 205 DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 1 of item 18) 200 ACCIDENT WAS UNDERLY N.G. OR CONTRIBUTING CAUSE OF DEATH (F EITHER, NOTIFY MEDICAL EXAMINERY 20e PLACE OF NJURY (Hame, farm, (City or fown) (County) (State) 20d NJURY OCCURRED 20c TIME OF INJURY Month, Day, Year MED foctors, street, office bldg , etc.) Hour am at work at work , 1966, that \$6 (we) last 55 to 9-20 21 | certify that 4) (this haspital) attended the deceased from 3-21-1966, and that death accurred at 10:20, from causes and an the date stated above -20 saw the deceased alive on 22b DATE SIGNED 22a SIGNATURE 9-21-66 DIRECTOR PHYS M.D. PHYS 22d ADDRESS Springfield State Hospital 22c. PHYSIC ANS NAME (Type) Arengo.

23c NAME OF CEMETERY OR CREMATORY

Paltimore C wetery

(County)

Baltimore,

by the hospital or attending physicion TO FUNERAL DIRECTOR: After this certificate had director, page 3 should be detached for use should be filed with the State Dept. of Health I 4 may be retained

executed with n 24 haurs after death

requires that the death certificate

funeral 1 and ter death

filled in by th papers. Pogr hin 72 hours a

ove carbon pap

remove

signed by the atter burial-transit permit burial, cremotion, o

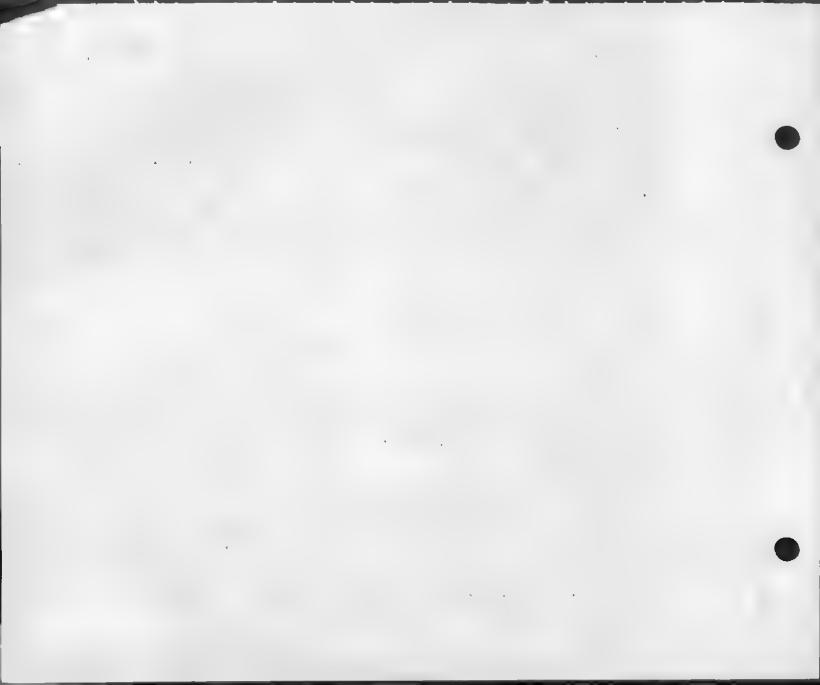
VR A15 (4) 20 M 1/66 230 BURIAL, CREMATION

REMOVAL (Specify)

23b DATE THEREOF

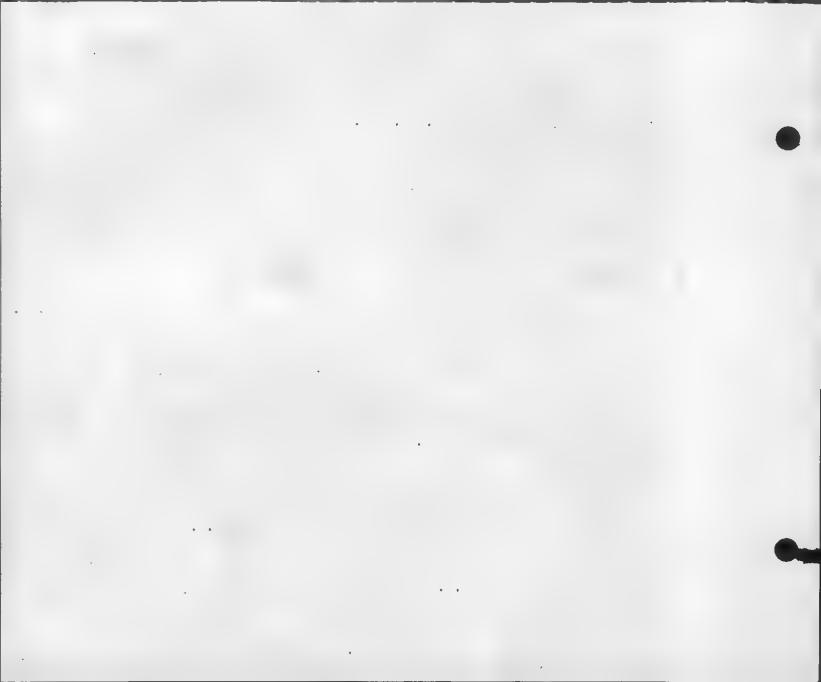
1/24/66

25b REGISTRAR'S SIGNATURE ADDRESS. 25a RECD BY REG STRAR 24 FUNERAL DIRECTOR Funer 1 Hone, I'c. schimune 3reh is Lane

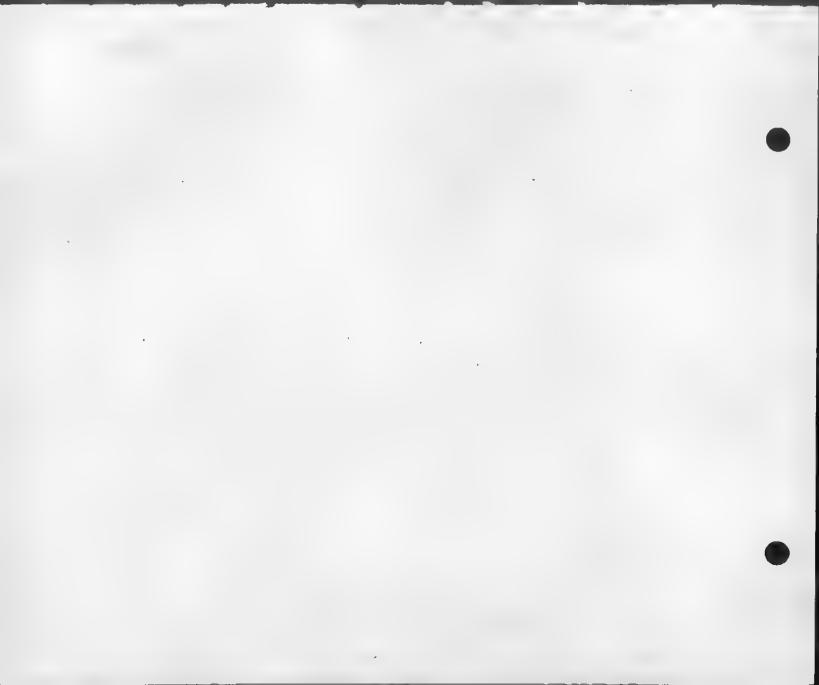


Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH by the funeral Pages 1 ond 2 tours ofter deoth. 24 hours after death. 2 USUAL RESIDENCE (Where deceased lived, it just tution. Residence before admission) PLACE OF DEATH b. COUNTY o COUNTY Marvland Washington Carroll MARY, AND CLENGTH OF STAY IN Th c CITY OR TOWN (If outside corporate limits, write RURAL and a ve nearest town) h CITY OR TOWN (If outside corporate limits filled in by the n papers Page itnin 72 hours o write RuRAL and a ve nearest town) 6v. 9m. 21d. Hagerstown Rural -- Sykesville d NAME OF HOSPITAL OR INSTITUTION (It not in hospital give street address) d. STREET ADDRESS e IS RESIDENCE ON A FARM? 728 George Street Springfield State Hospital AEZ NO DC Within requires that the deoth certificate be executed within completely fill 3 NAME OF Middle 4 DATE Month OF DEATH DECEASED 28 19 66 Gladvs Dalev (Type or pnnt) IF UNDER I YEAR LIF UNDER 24 HRS 9 AGE 'n years S SEX 6 COLOR OR RACE 7 MARRIED NEVER MARR ED 8 DATE OF BIRTH 78 last birthday) 2/18/88 in-any-e W DOWED D VORCED female white 10b KIND OF BUSINESS OR 12 CIT ZEN OF WHAT 10n, USUA, OCCUPATION (Give kind of work done 11 BIRTHPLACE (County & State or fore an country) INDUSTRY COUNTRY? ease during most of working life, even if retired) USA physician c 14 MOTHER'S MAIDEN NAME 13 FATHER'S NAME Inde (alari vi lili 16 SOCAL SECURITY NO 17 INFORMANT 15 WAS DECEASED EVER IN U.S. ARMED FORCES? permit. (Yes, no or unknown) (If yes a ve wor or dates of service) 220-09-9074 Springfield Hospital records, Sykesville, Md. no crematian, NTERVAL BETWEEN 18 (AUSE OF DEATH (Enter only une couse per line for (a) (b), and (c)) signed by the burial-transit p ONSEL AND DEATH PART I DEATH WAS CAUSED 8Y Bronchopneumonia IMMEDIATE (AUSE (O) attending physicion. DUE TO Arteriosclerotic cardiovascular disease--Conditions, if any, which gave rise to immediate couse (a). confestive failure years DUE TO stating the under ving couse as the prior tal O FUNERAL DIRECTOR: After this certificate has been Generalized arteriosclerosis vears PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0)
Chronic brain syndroms with cerebral arteriosclerosis with
psychotic reaction. WAS AUTOPSY PERFORMED? for use i Heolth p YES 🗀 NO P by the nospital ar CERTIFICAT 205 DESCR BE HOW INJURY OCCURRED (Enter notice of injury in Part I or Part II of item 18.) 200 ACCIDENT WAS UNDERLYING [detached for the Dept. of H OR CONTRIBUTING [CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER 20c. TIME OF NJURY Month, Day, Year 20d INJURY OF CURRED 20e PLACE OF NJURY (Home form (City or town) (County) (Stote) Hour om Not While factory, street, office bida, etc.) ATTENDING of work ot work 19 59 , ta. 1966, that Of (we) last 21. I certify that Ox (this haspital) attended the deceased from 9/20/ plrods Page 4 may be retained 1966, and that death occurred at 1:35%, from causes and an the date stated above director, page 3 should should be filed with the 9/28/ saw the deceased alive an 22b. DATE SIGNED 220. SIGNATURE 9/28/66 M.D. DIRECTOR 22d ADDRESS Springfield State Hospital 22c PHYSIC ANS Suha Ozgun, M.D. NAME (Type) Sykesville, Maryland 23b DATE THEREOF 23c NAME OF CEMETERY OR CREMATORY 23d LOCAT ON (City or Town) 23o BURIAL CREMATION (County) (Stote) REMOVAL (Specify) n. ADDRESS 250 REC D BY REGISTRAR 25b REGISTRAR S SIGNATURE 24 FUNERAL DIRECTOR VR A15 (4) DATE 20 M 1/66

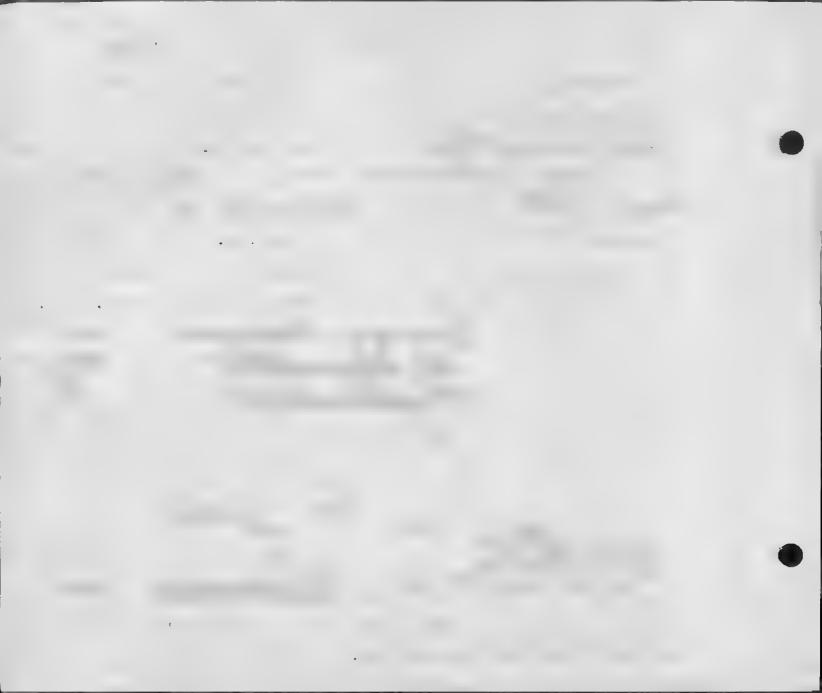
MARYLAND STATE DEPARTMENT OF HEALTH



1	MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH 19570
after death. the funeral ges 1 and 2 after registh.	1. PLACE OF DEATH a. COUNTY 2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission a. STATE b. COUNTY
rs after by the Pages 1 urs after	b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) MARYLAND c. LENGTH OF STAY IN 1b c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
ted within 24 hours completely filled in by ve carbon papers. Pag event, within 72 hours	d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) d. STREET ADDRESS e. IS RESIDENT ON A FARMS
ithin 2 itely fill bon pap within	3 NAME OF First Middle Last 4. DATE Month Day Year
uted wi	DECEASED (Type or print) HOLLIC VIGURE ARRIED NEVER MARRIED 8. OATE OF BIRTH 9. AGE (In years FUNDER 1 YEAR FUNDER 24 HI last birthday) Months Days Hours Mir
e execu an and ie remo	WIDOWED OIVORCED COUNTY State, or foreign country) 12. CITIZEN OF WHAT UNDUSTRY 10a. USUAL OCCUPATION (Give kind of workdone 10b. KIND OF BUSINESS OR II. BIRTHPLACE (County & State, or foreign country) 12. CITIZEN OF WHAT COUNTRY?
icate b physici n pleas val, and	13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME
ath certificate be executed within attending physician and completely rmit. Then please remove carbon in, or removal, and in any event, with	15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT Address (Yes, no, or unknown) (If yes give war or dates of service)
that the de hysician. signed by the urial-transit pe urial, cremat o	18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, If any, which gave rise to Immediate cause (a), stating the underlying cause last. (c)
The lal or a ficate or use	PARTII. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS AUTOPS: PERFORMED? YES NO [1] ACG. DEFINITION WAS LINDERLYING 1 20b. OFSCRIBE HOW INJURY OCCURRED. (Enter nature of Injury In Part 1) of Part 11 of Item 18.)
HY he this De eta	20c. TIME OF INJURY Month, Oay, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, Hour a.m. While Not Whil
TO HOSPITAL OR ATTENDING P Page 4 may be retained by the FUNERAL DIRECTOR: After director, page 3 should be d slould be filed with the State	21. I certify that (I) (this hospital) attended the deceased from 1914, and that death occurred at 2014 M. from the causes and on the date stated above 22a. SIGNATURE 22b. DATE SIGNED 22c. PHYSICIAN'S NAME (Type) 22d. ADORESS
TO HOS Page TO FUN direct should	23a. BURIAL CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City, town or county) (State) REMOVAL (Specify) Purple 7 10-2-50 12i v Jenotopy 23d. LOCATION (City, town or county) Purple 7 10-2-50 12i v Jenotopy 23d. LOCATION (City, town or county)
VR A15 (4) 20M 1/65	24. FUNERAL DIRECTOR ADDRESS 25a. REGISTRAR'S S. GNATURE DATE DAT



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, If institution Residence before edmission) 1. PLACE OF DEATH a. COUNTY b. COUNTY Baltimore a. STATE by the and 2 death. MARYLAND b CITY OR TOWN at odiside corporate aim ts, E LENGTH OF STAY IN 16 c. CITY OR TOWN .If outside corporate I in ts. write RURAL and give nearest town write RURAL and give nearest town Essex (21) Pages d. STREET ADDRESS IS RESIDENCE give street address) ON A FARM? YES NON papers. Silver Lane Rd. 3. NAME O 2 4. DATE Day Year DECEASED within (Type or print, Dora Eichhorn) DEATH 19 pou 9. AGE In years IF UNDER I YEAR JF JNDER 24 HRS NEVER MARRIED F car last-birthday) | Months WIDOWED DIVORCED physician e remove 10a. USUAL OCCUPATION (Give kind of work 10b KIND OF BUSINESS OR INDUSTRY 12 CITIZEN OF WHAT COUNTRY? done during most of working life, even if retired) Baltimore. Md. TISA Home Housewife please 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME attending Katherine Charles Eisenberg 15. WAS DECEASED EVER IN J.S. ARMED FORCES? ' 16. SOCIAL SECURITY NO. 17. ENFORMANT Address (Yes, no, or unknwn) (Ifyesgivewarordatesofservice) 81 Silver Lane Rd. Balto. 21 Marie Rosenkilde None 18 CAUSE OF DEATH |Enter only one cause per | ne fer (a) (b), and (c), INTERVAL ÉETWEEN PART I DEATH WAS CAUSED BY: burial-transit ial, cremation, MMEDIATE CAUSE (a) DUE TO Conditions, if any, which' gave rise to immediate cause **DUE TO** la), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1,2) 19 WAS AUTOPSY CERTIFICATION PERFORMED? prior 1 NO R: After this ce detached for u 20a ACCIDENT WAS UNDERLYING [] | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) OR CONTRIBUTING [] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c TIME OF INJURY Month, Day, Year 20d INJURY OCCURRED | 20e PLACE OF INJURY (Home, farm, 20f. (City or lown) (County) (State) factory, street, office bldg., etc.) While Not While Hour am. Dept. RECTOR: at work at work p m 21. I certify that (I) (this hospital) attended the deceased from 1962, that (I) (we) last shoul 30 M, from the causes and on the date stated above1964, and that death occurred al saw the deceased alive on a FUNERAL ector, page filed with th PHYS. D RECTOR M.D. HOSPITA 1 23c. NAME OF CEMETERY OR CREMATORY 23d, LOCATION (City, lown or county) (State) 23a, BURIAL, CREMATION, 23b DATE THEREOF 0530 REMOVAL (Specify) Baltimore, Maryland Oak Lawn Cemetery Burial 24 FUNERAL DIRECTOR SIGNATURE ADDRESS 25a, REC'D BY REGISTRAR 25b, REGISTRAR'S SIGNATURE VR A15 [4] Eastern Ave. 20M S-63



			MARYLANI	STATE DE	ARTMENT OF	HEALTH		
	DIVIS	ION OF STATISTIC	AL RESEARCH	ND RECORDS,	301 W. PRESTON	STREET, BALT	MORE 1, MAI	YLAND
(# /]	- (² 6	CI	RTIFICATE	OF DEATH		1258	1
ould show	1. PLACE OF	DEATH			2. USUAL RESIDENCE			ince before admission)
fur sh	a_COUNTY	nd &		MARYLAND	* STATE	ь c	Cle les Le	nes VL
bot the sath	b. CITY OR T	OWN (if outs de corporate	imits c LENG	TH OF STAY N 16	CITY OR TOWN IN	puls de corporate limits.	and I	
24 1 de 19		RALL and give neerest town)	rd 24	rozmo.	Pettsmergh	~ 12		
affra affra	DE NAME OF	HOSPITAL OR INSTITUTIO	N ,if not in hospiter, give	street eddress	d STREET ADDRES			IS RESIDENCE ON A FARM?
V V	Joseph	un num	my Home. 12	8N main	ST 210	9 Bughtin	Rd	YES NO
28er	3. NAME OF DECEASED	- A D	ું કહીં -	Middle	Lesi	4 DATE A	North De	y Yeer
mpl pag	(Type or print		es alr	eda En	rowert	DEATH	9 1	1966
S on bon withiw	5. SEX	6 COLOR OR RA	CE 7. MARRIED NEV	ER MARRIED B	DATE OF BIRTH	9 AGE (In y last birthd	ears IF UNDER 1 YEAR	
o carl	- L'arrens	-come	WIDOWED	DIVORCED 🔲	pul19,180	4.5 (7) 1/7	rs, ,	1
ficat cian ove eve		CCUPATION (Give kind of vist of working life, even if re		ISINESS OR INDUSTRY	11 BIRTHP ATE County	& State or fore gricou	19	OF WHAT COUNTRY?
hysi hysi rem rem		unge-			Drivetina MAIDEN N.	1 Balteli 1	nd c	C.SA-
ase ase	13. FATHER'S N	AME IN T	el.	'	MOTHER'S MAIDEN N.	TE A	leton-ale	
e in a series	15 WAS DECEA	SED EYER IN U.S ARMED I	FORCES 14 SOCALS	EC. ISSITY NO. 17 TH	FORMANT A		dans	
hen at te		own) (If yes give war or dates		Jeonii No 1	1 7 de	2.11	C3 Comel	my JL
that the the movement	Tis. caus	E OF DEATH Enter only	one cause per line for (a).	the and (c).1	wee James	· (Or cher)	Emall	NTÉRVAL BETWEEN
iciar by brmi		I. DEATH WAS CAUSED BY	13	un-les-	27-3 x	an operationed		DNSET AND DEATH
ned iit p		IMMEDIATE CAUSE		* * * *	,			7
w re po	Conditions,	if eny, which	The ter	arrell a	rtic Cough	E-64 2-60	a Car	o come
o fa nodii Sen ial-f	gave rise to	immediate cause			\wedge	*		Ť
atte atte bur bur iale	cause last.	the underlying	(c)		· sin	24		
The property of the property o	Z PART I	OTHER SIGNIF CANT COL		TO DEATH BUT NOT	RELATED TO THE TERM NA	AL D SEASE CONDITION	GIVEN IN PART 1(+)	19 WAS AUTOPSY PERFORMED?
ICIT iffice iffice or as	E C							YES NO
hos cert cert r us prio	20a. ACCID OR CONTRIL (IF EITHER,	BUTING CAUSE OF DEA		W INJURY OCCURED.	Enter neture of injury in Pe	rt I or Pert II of item 18.		
RA 참 하 하 하		NOTIFY MEDICAL EXAMIN	(ER)					
He de	20c. TIME (OF [NJURY Month Day, e.m.		CCURRED 20e PLACI While fector	OF INJURY (Home, term r, street, office bldg., etc.)	20f. 'City or town	(County)	(State)
NDI inec		p.m. 1	<i>,</i> , ,	vork				
Per	21. i ce r	tify that (I) (this ho	spital) attended the					that (P) (we) last
ate of the p		deceased alive on . (Dung 3.0 19	66 and that d	eath occurred at 7 A	M, from the caus	ses and on the d	
Sirk Sirk	220 SIGNA	111/11/1	and a l		ATTENDING ME	D. STAFF	П	9 226 DATE SIGNED
AL AL PLE	22c. PHY51	CIANS	To war and	M D	PHYS DIF	TON	L 1	11166
Pag ERA Wil		(Type) /	FLATA	un	x 12 20 1	> + 00	Alle	
TON Ctor.		REMATION, 1 236 DATE T	HEREOF 238 IN	AME OF CEMETERY OF	CREMATORY,	23d. JOCATION (CIT	(lown or county)	(State)
Ogodina C	REMOVAL L	Specify) 9/3/6	6 Stre	ive Bus	Cometing.	Parto (_ 4	fich.
HH	24 FUNERAL DI	RECTOR'S SIGNATURE	4 / AI	DDRESS	250 REC'E	BY REG STRAR : 25b	REGISTRAR S S GN	ATURE
VR A15 (4)	Tept	TX- E Kene	J.fet.s.	nosteat	ALL DATE S	EP 5 1966	Milane	en Judge
~		-				_	V	110





MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE DEATH and-2 death: after death. 1. PLACE OF DEATH USUAL RESIDENCE (Where deceased lived, If institution: Res'dence before admission) a. COUNTY a. STATE b. COUNTY after the MARYLAND remove carbon papers. Pages any event, within 72 hours aft b CITY OR TOWN (if outside corporate limits. C. LENCTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) write RURAL and give nearest town) 24 hours d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) d. STREET ADDRESS IS RESIDENCE ON A FARM? No 🔀 YES withIn 3. NAME DF Middle Last DATE Month DECEASED (Type or print) DEATH 194 executed 6. COLOR OR RACE DATE OF BIRTH 7. MARRIED ACE (In years | IF UNDER 1 YEAR IF UNDER 24 HRS. NEVER MARRIED last birthday) | Months | Days DIVORCED WIDOWED X .= IDa USUAL OCCUPATION (Give kind of work done | IDb. KIND OF BUSINESS OR (County & State, of foreign country) 12. physician ease during most of working life, even if retired) INDUSTRY and 13. FATHER'S NAME ficate 9 14. MOTHER'S MAIDEN NAME removal Ing pt Then KIBUN transit permit. 15. WAS DECEASED EVER INU.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT Address (Yes, no, or unknwn) (If yes give war or dates of service) 菲 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] 18. INTERVAL BETWEEN requires that the -transit á ONSET AND DEATH PART I. DEATH WAS CAUSED BY: CHRONIC CARDIOVASCULAR DISEASE attending physician. been signed I the burial-trai or to burial, cr IMMEDIATE CAUSE (a) DUE TO ARTERIOSCLEROSIS AND CHRONIC MYOCARDITIS 20+ yrs. Cenditions, If any, which (b) rise to Immediate DUE TO cause (a), stating the as th DETERIORATION ADVANCED SENTLE underlying cause last. The law CERTIFICATION PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION CIVEN IN PART 1(a) WAS ALTOPSY for use Health p PERFORMED? certificate YES NO X PHYSICIAN: 2Da. ACCIDENT WAS UNDERLYING OF CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) DESCRIBE HOW INJURY OCCURRED, (Enter nature of Injury in Part 1 or Part 11 of Item 18) r this cert detached te Dept. of MEDICAL 2Dc. TIME OF INJURY Month, Day, Year I 20d INJURY OCCURRED | 20e, PLACE OF INJURY (Home, farm, 2Df. (City or town) (State) (County) be de State Hour a.m. factory, street, office bldg., etc.) SECTOR: After 3 should be diwith the State While Not While at work AFTENDING 19 at work ITAL OR ATTENDI 21. I certify that (I) (big baseled) attended the deceased from 18/June /60 to 12/Sept/66 19 and that death occurred at 2 A.M. from the causes and on the date stated above. /Sept/66 saw the deceased alive on 12 22a. SICNATURE 22b. DATE SICNED DIR page : M.D. DIRECTOR DE Sept HOSPITAL FUNERAL director, p PHYSICIAN'S 22d. ADDRESS NAME (Type) Box 54. Sykesville, Maryland Jr. Wm. H. Lawson 23a. BUR.AL, CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY LOCATION (City, town or county) (State) REMOVAL (Specify) 0 FUNERAL DIRECTOR **ADDRESS** 258. REC'D BY RECISTRAR 25b. REGISTRAR'S SIGNATURE VR AI5 (4) 2DM 1/65



TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

24 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within Page 4 may be retained by the hospital or attending physician.

Ų

VR A15 (4) 20M 1/65

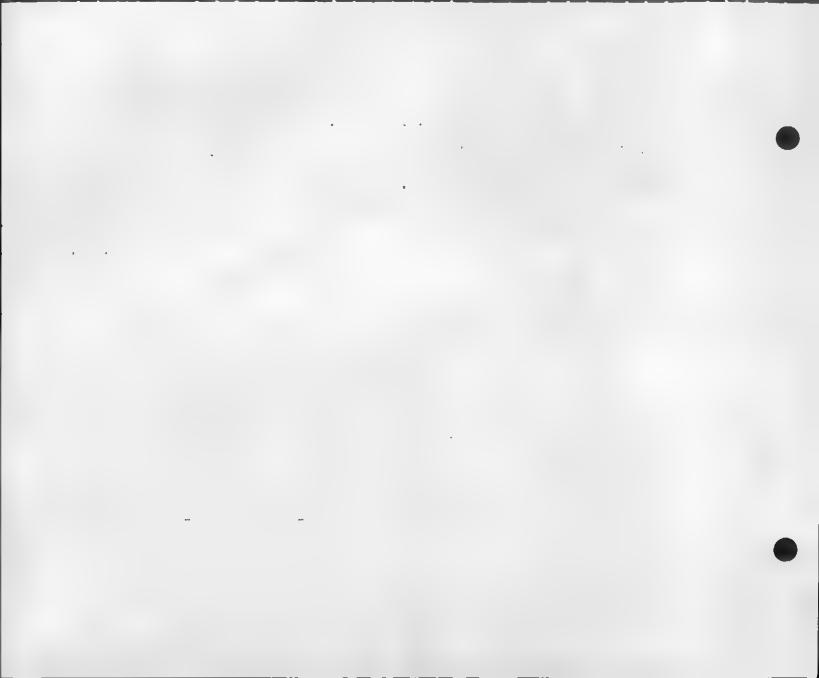
MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH 19554

1.	PLACE OF DEATH a. COUNTY A. COUNTY MARYLAND 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) b. COUNTY b. COUNTY
_	b. CITY OR TOWN (if outside corporate limits, c. LENGTH OF STAY IN 1b c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) write RURAL and give nearest town)
	WRAL-SYKESUITE/MOTTH-2499/3 CIT
	d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) d. STREET ADDRESS S. S. HOSPITAL OR INSTITUTION (if not in hospital, give street address) d. STREET ADDRESS ON A FARM? 5210 Wilton Hell HTS AND YES NOW
3.	NAME OF DECEASED (Type or print) SANCEL HACK ETT FOX-SC DEATH 9 1/ 1966
5.	6. COLOR OR RACE 7. MARRIED NEVER MARRIED 8. DATE OF BIRTH 9. AGE (In years IF UNDER 14 ARS. Hours Min.
10 du	a. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR II. BIRTHPLACE (County & State, or foreign country) 12. CIT-ZEN OF WHAT COUNTRY? INDUSTRY A PART COLUMN COUNTRY?
13	3. FATHER'S NAME 14. MOTHER'S MAIDEN NAME 7 17 17-15 1 TILL
١.	SAMUEL TOX
1; (Y	5. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT Address 5.5, 105 PTG.
	NO 1220-03-937/A HOSPITAL RECORD - SYKESUINE-
	18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c), 1 ONSET AND DEATH
	PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) KILL CARDOLLA
	DUE TO PORTO TO TO
	gave rise to immediate (b) Celebral allerosellions.
	cause (a), stating the DUE TO
NO	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 119. WAS AUTOPSY
CERTIFICATI	Bronchone Circumice. PERFORMED? YES NO [
TIFI	One ACCIDENT Was HANCED VINC TO 1 20th DESCRIPE NOW IN HIDY OCCUPED (Factor nature of Injury In Bart Loy Bart II of Ham 19)
CE!	OR CONTRIBUTING THE CAUSE OF OEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
ICAL	20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, 20f. (City or town) (County) (State)
MEDICAL	Hour a.m. p.m. 19 While at work At work At work While at work At
	21. I certify that (D (this hospital) attended the deceased from 7-18, 1965 to 9-11, 1965 that (I) (we) last
	saw the deceased alive on 19 Cand that death occurred ato. 2M, from the causes and on the date stated above.
	22a. SIGNATURE 22b. DATE SIGNED 22c. SIGNATURE 1 2c. DATE SIGNED 22c. DATE SIGNED 22c. DATE SIGNED 22c. DATE SIGNED
	22c, Physician's 22d, Address 5 1/2 P + 6
L	NAME (Type) FRANCES KEID NOBOKS 35 FRES. 1/e, no
23	a. BURIAL, CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City, town or county) (State)
	3 REMOVAL (Society) 4/15/66 Mit Chine Landailation May
3	4. FUNERAL DIRECTOR ADDRESS - LEGISTRAR 25b. REGISTRAR 25b. REGISTRAR'S SIGNATURE
1	171147 Lyen Tenual Home 112 delegren DATE SEP 1 1 1966 D'anten lus

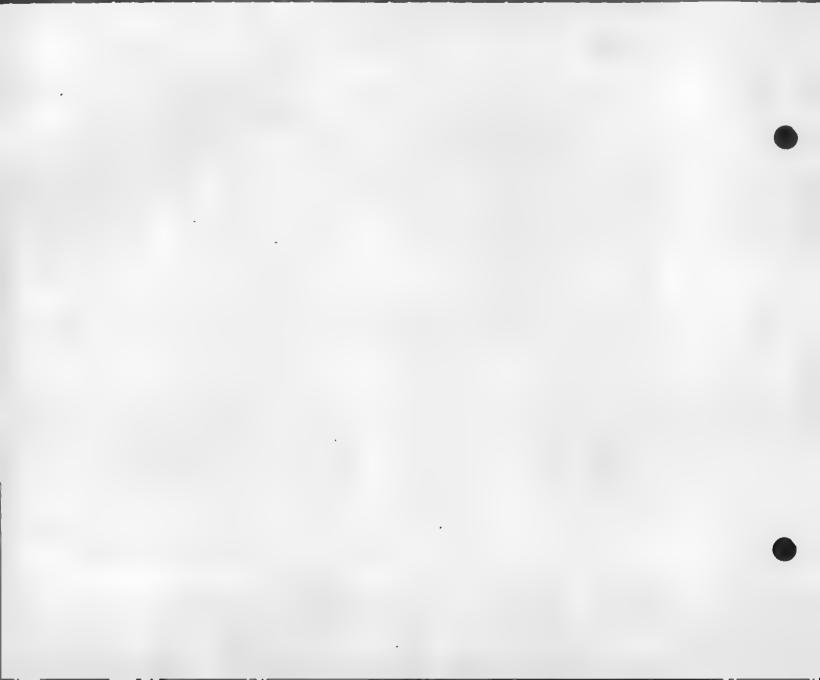


Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH 24 hours after death. Résidence before admission 2 USUAL RESIDENCE (Where deceased lived if instit it on i. PLACE OF DEATH Carroll **b** COUNTY MARYLAND Baltimore City Marvland b CITY OR TOWN , I outside corporate limits, LENGTH OF STAY IN 16 c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville H2vrs.llmos.hdvs. Baltimore e IS RES DENCI d NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) d STREET ADDRESS popers ON A FARM? filled i Springfield State Hospital 1104 S. 3rd St. YES NO DE within executed within corban 3 NAME OF Middle DATE Month campletely DECEASED ΔF FREDERICK J. GEGNER SEPTEMBER 19 66 DEATH Type or print) LIF UNDER 24 HRS B DATE OF BRITH AGE //r years S SEX 6 COLOR OR RACE 7 MARRIED NEVER MARRIED TO emove Jost birthday) Hours ?-?-189/ DIVORCED White WIDOWEO Male 12 CIT ZEN OF WHAT 100 JSUAL OCCUPATION, Give kind of work done 10b KIND OF BUSINESS OR 11 B RTHPLACE (County & State or foreign country) that the death certificate be COUNTRY? during most of working life, even if retired) INDUSTRY or removal oner U.S.A. Maryland Laborer 14. MOTHER'S MAIDEN NAME 13 FATHER'S NAME William Gegner Lena Zimmerman permit. The IS WAS DECEASED EVER NUS. ARMED FORCES? 17 INFORMANT 16 SOCIAL SECURITY NO Address (Yes, no, or unknown) (If yes give wor or dotes of service) 220-54-6933 Records, Springfield State Hospital Νo crematian, INTERVAL BETWEEN 18. CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c).) signed by the buriol-transit public buriol, crematic Hours PART I. DEATH WAS CAUSED BY: Acute pulmonary edema IMMEDIATE CAUSE (o) DUE TO Conditions, if any, which gave Arteriosclerotic heart disease Years rise to immediate couse (o), DUE TO attending p stating the underlying couse t to PART II OTHER SIGNALCANT CONDITIONS CONTRIBUTING TO GEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART (c) 19 WAS AUTOPSY PERFORMED? Schizophrenic reaction, hebephrenic type detoched for use NO X 200 ACCIDENT WAS UNDERLYING TO 205 DESCRIBE HOW INJURY OCCURRED (Enter noture of injury in Port 1 or Port 11 of Item 18) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) Dept. MEDICAL 20d INJURY OCCURRED 20e PLACE OF IN. JRY (Home, form, (City or town) (State) 20c T.ME OF INJURY Month, Doy, Year foctory, street, office bldg., etc.) Rour o.m. Not While at work Poge 4 moy be retained by the FUNERAL DIRECTOR: After ot work __, that (I) (we) last 21 I certify that (I) (this hospital) attended the deceased fram 19-21-23 ____, and that death accurred at 2:35 9-25-66 saw the deceased alive an_ 19 fram causes and an the date stated above 22b. DATE SIGNED 22o. SIGNATURE 9-26-66 k DIRECTOR M.D PHYS PHYS director, poge 3 should be filed a Springfield State Hospital 22d ADDRESS 22c PHYSICIAN S NAME (Type) Sykesville. Octavio A. Ruiz, M. D. Maryland 23d LOCAT ON (City or Town 23c NAME OF CEMETERY OR CREMATORY 230 BURIAL CREMATION. 23b DATE THEREOF (Stote) REMOVAL Spec (y) 250 REC'D BY REGISTRAR 24. FUNERAL DIRECTOR 25b REGISTRAR'S SIGNATURE VR A15 (4) 20 M 1/66

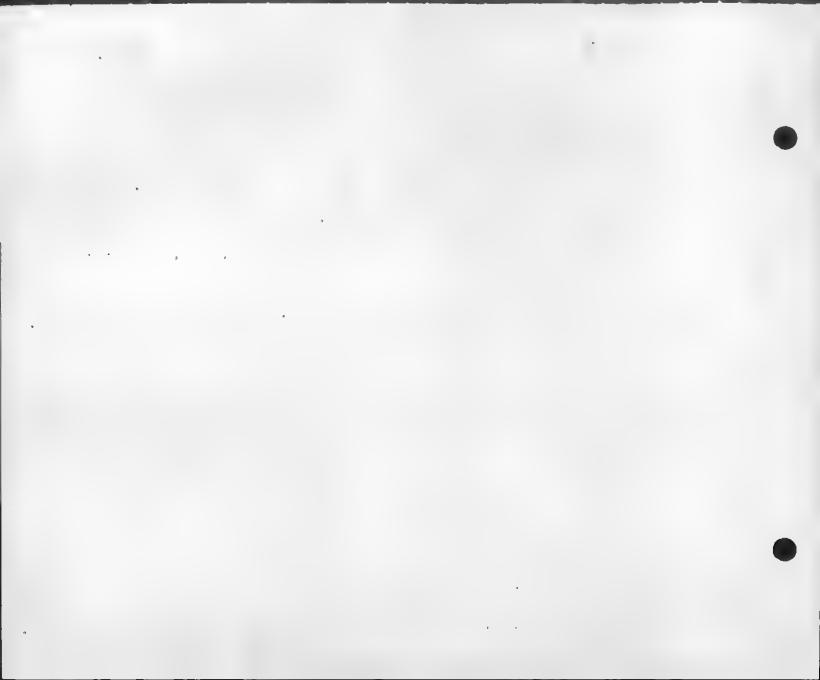
MARYLAND STATE DEPARTMENT OF HEALTH



MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH uneral l and 2 IISUAL RESIDENCE (Where deceosed I ved, if institution PLACE OF DEATH n COUNTY b COUNTY MARYLAND c LENGTH OF STAY N 1b c CIY OR TOWN (If oxigide corporate imits write RURAL and a ve nearest town) b CITY OR TOWN If outside impurate limits, write RURAL and give nearest town d STREET ADDRESS e IS RESIDENCE ON A FARM? Ear I NC Z 3 NAME OF 4 DATE carban Dov DEATH AGE /In years IF UNDER 1 YEAR 7 MARR FD remave ost birthdov Months WIDOWED D VORCED 2 CITIZEN OF WHAT 0b KIND OF BUSINESS OR 11 BIRTHPLACE (County & State or foreign Jountry) OCCUPATION 'Give kind of work done mest of working life every firet red) physician a **INDUSTRY** The law requires that the death certificate me - bru 13 FATHER S NAME 15 WAS DECEASED EVER IN U.S. ARMED FOR PS?
(Yes, no ar unknown) , fiyes give war or dates of service) 16. SOCIAL SECURITY NO 17 INFORMANT cremation IB CAUSE OF DEATH (Enter only one couse per line for (o), (b) and (c) signed by the burial-transit p PART I DEATH WAS CAUSED BY HEMORRHAGE INTRACEREBELLAR .MMED.ATE CAUSE (0) DUE TO PERTENSIVE CARDIOVASCULAR Conditions, if ony, which gove rise to immediate couse (a). stating the underlying couse DISEASE PART IL OTHER SIGNIF CANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(0) WIESS GASTROESOPAAGEAL 10 200 ACCIDENT WAS UNDERLYING 205 DESCRIBE HOW N.JRY OCCURRED (Enter nature of injury in Port 1 or Port 1 of tem 181) detached f te Dept of l OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER 20e PLACE OF INJURY (Home, form, 20c T ME OF INJURY Month, Day, Year 20d INJURY OCCURRED (City or fown) (County) (State) O FUNERAL DIRECTOR: After this foctory, street, office bldg., etc.) 220 SLGMATURE 22b. DATE SIGNED M.D. DIRECTOR director, page shauld be filed 22d. ADDRESS NAME (Type) DATE THEREOF 23o. BUR AL CREMATION 23c. NAME OF CEMETERY OR CREMATORY LOCATION (City or Town) 25b REGISTRAR S SIGNATURE 24. FUNERAL DIRECTOR 25a REC D BY REGISTRAR VR A15 (4) 20 M 1/66



MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH 2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission PLACE OF DEATH a COUNTY b COUNTY Carroll MARYLAND Balt in ore c CITY OR TOWN (f outside corparate limits, write RURAL and give nearest tawn) b CITY OR TOWN (If outside carporate limits, CLENGTH OF STAY IN 16 write RURAL and give nearest town) Reisterstown 6 days Westminster d NAME OF HOSP TALL OR INSTITUTION (If not in hosp tal, give street address) d. STREET ADDRESS ON A FARM? Carroll County General Hospital Glen Falls Road NO K 3 NAME OF 4 DATE Month DECEASED Sept. 11 Wille Keller Green (Type or pont) IF LINDER 1 YEAR 6. COLOR OR RACE 7 MARRIED TO NEVER MARRIED B DATE OF BRTH 9 AGE (n years Last birthday) 8, 1889 Femal.e White WIDOWED DIVORCED 10a USUAL OCCUPATION (Give kind of work done 10b KIND OF BUSINESS OR 11 B RTHPLACE (County & State or foreign country) 12. CIT'ZEN OF WHAT regures that the death certificate be during most of warking life, ever if retired). U.S.A **NDUSTRY** ous ewife Carroll Co... 13 FATHER'S NAME 14 MOTHER'S MADEN NAMI John Wesley Keller Mary Gorsuch 15 WAS DECEASED EVER N U.S. ARMED FORCES? (Yes, na, ar unknawn) ((If yes give war ar dates of service) 16 SOCIAL SECURITY NO 17 INFORMANT Address Box 08 Alen Rayner H. Creen None 1B. CAUSE OF DEATH (Enter any one cause per line for (a), (b) and (c).) burial-transit PART I. DEATH WAS CAUSED BY-ONSET AND DEATH IMMEDIATE CAUSE (a) DUE TO signed | Conditions, if any, which gave rise ta immediate cause (a), DUE TO stating the underlying cause etached for use as the Dept. of Health prior to PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) WAS AUTOPS PERFORMED? Interescleration Neut Disease. 205 DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part (or Port) of item 18) 200 ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. I.ME OF INJURY Month, Day, Year 20d INJURY OCCURRED 20e PLACE OF NJURY (Hame, form (City or tawn) (County) (State) TO FUNERAL DIRECTOR: After this factory, street, affice bldg., etc.) 21. I certify that (1) (this hospital) attended the deceased from Sept 5, 1966, to Sept 11 , 19 64 that (I) (we) lost sow the deceased glive on Sept 11, 19 6, and that death occurred of 10 3 M, from couses and on the date stated above. 22a SIGNATURE 22b. DATE SIGNED director, page 3 should be filed v M.D. DIRECTOR 22d. ADDRESS 22c. PHYSICIAN'S NAME (Type) 23c NAME OF CEMETERY OR CREMATORY BUR AL CREMATION REMOYAL (Specify) Druide Ridge Cemetery Pikesville, Balto.Md 2So REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE 24 FUNERAL DIRECTOR VR A15 (4) Owings Mills, Maryland DATE SEP



MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE within 24 hours after death 2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission PLACE OF DEATH a. COUNTY b. COUNTY CITY DR TOWN (If outside corporate mits, write RuRA, and a ve negrest town) I potside corporate limits write RURA, and give nearest town) e IS RESIDENCE ON A FARM? YES NO d STREET ADDRESS OR NST TUTION (final in hospital give street address) completely fu 3 NAME OF 4 DATE Month DECEASED (Type or pant) executed FUNDER! YEAR 7 MARR ED NEVER MARRIED DATE OF BIRTH 9. AGE (In years emove lost buthday) Doys W.DOWED DIVORCED IDo S. A. OCC. PAT ON (Give kind of work done 1Db KIND OF BUSINESS OR M BIRTHP, ACF (ounty & State or fore an country) 12 CIT ZEN OF WHA] requires that the death certificate be during most of working the even if retired) INDUSTRY KISE VILEE pled 13 FATHER'S NAME signed by the attending physic burial-transit permit. Then pl burial, cremation, or removal, 7/3// 15 WAS DECEASED EVER IN U.S. ARMED FORCES? 16 SOCIAL SECURITY NO 17 INFORMANT (Yes no or unknown) (It yes a ve wor or dates of service) MANCHESTE IB CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c).) INTERVAL BETWEEN ONSET AND DEATH PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Conditions, if any, which gave rise to immediate couse (a), DUE TO stating the underlying couse as the has been lost. PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) WAS AUTOPS1 PERFORMED? be detached for use State Dept. of Health YES [NO 200 ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH 205 DESCRIBE HOW INJRY OCCURRED (Enter nature of injury in Port L or Port L of Item 18.) (IF EITHER, NOTIFY MEDICAL EXAMINER 2Dd NJURY OCCURRED 20e P.ACE OF INJURY (Home, form, (City or fown) (County) (Stote) 20c. TIME OF INJURY Month, Doy Year TO FUNERAL DIRECTOR: After th Not While factory, street, office bldg., etc.) at work at work 21. I certify that (1) (this haspital) attended the deceased from, and that death accurred at 3 3 M, from causes and an the date stated above. 196 6 saw the deceased alive an. 220. SIGNATURE 22b. DATE SIGNED director, page should be filed 22c. PHYSICLMS 22d. ADDRESS NAME (Type) BUR AL, CREMATION, DATE THEREOF 23d. LOCATION (City or Town) (County) REMOVAL (Spec full FUNERAL DIRECTOR 250 REED BY REGISTRAR 2Sb. VR A15 (4)



1 ()	MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MA	RYI AND
FOR STATE	MEDICAL EXAMINER'S CERTIFICATE OF DEATH	2598
HEALTH DEPT.	1. PLACE OF CEATH a. COUNTY 2. USUAL RESIDENCE (Where deceased lived, If institution: Real COUNTY)	2
essary, inneral ray be truent death.	b. CITY OR TOWN (If outside corporate limits, c. LENGTH DE STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL	ore City and give nearest town)
decessary, the funeral 5 may be be bartment feer death.	write RURAL and give nearest town) Sykesville löyrs. 6mos. 17dys. Baltimore	A
3 - 45 - 45	d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d. STREET ADDRESS Springfield State Hospital 1132 Carroll St.	e. IS RESIDENCE ON A FARM?
and 3 to 13. Page 18. State D 2 hours a	3. NAME OF First Middle Last 4. DATE Month	Oay Year
any # # F	OECEASED (Type or print) GEORGE EDWARD HAYSLUP, JR. DEATH SEPTE BEL	6 19 66
th. If a form P form P within	5. SEX 6. COLDR DR RACE 7. MARRIEO NEVER MARRIEO 8. DATE DE BIRTH 9. AGE (In year: IFUNCER: last birthday; Months of the WIODWED DIVDRCED (9-23-0).	TYEAR FUNDER 24 HRS Days Hours Min.
ive Pag with f and 2	10a. USUAL OCCUPATION (6, ve kird of work done, 10b. Kino DF BUSINESS OR 11. BIRTHPLACE (State or foreign country) 12. CI	TIZEN DF WHAT
after Give mg w s 1 s	Machinist Maryland	U.S.A.
n 18.	George E. Havslup, Sr. Pauline Brown	
24 ho Office office	George E. Hayslup, Sr. Pauline Brown 15. WAS DECEASED EVER IN U. S. ARMEO FORCES? 16. SOCIAL SECURITY ND 17. INFORMANT Address (Yes, no, or unknown) (If y sgine war or dates of servic.)	
within pencil in miner's permit.	No 217-09-4052 II Records, Springfield State Hos	pital
n per amin t per	18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.] PART I. DEATH WAS CAUSEO BY: IMMEDIATE CAUSE (a) Acute myocardial infarction	INTERVAL BETWEEN DNSET AND DEATH Linutes
ecute at Ex ransi on, o	DUE TO	Tulutes
"pending" in "pending" in "fedical Exam: Medical Exam: burial-transit cremation, or i	Conditions, if any, which gave rise to immediate (b) Coronary artery thrombosis	Minutes
ould "	cause (a), stating the DUE TD underlying cause last (c) Coronary arteriosclerosis	Years
ate sho ne wor the Chi sed as burial	PART II. DITHER SIGN FICANTICONOITIDES CONTRIBUTING TO GEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONCITION GIVEN IN PART 1(a) Schizophrenic reaction, catatonic type	19. WAS AUTOPSY PERFORMEO?
to the track of th		YES NO
vriting rded to uld be	20a. EXTERNAL CAUSE WAS PRIMARY or CONTRIBUTING CAUSE OF DEATH.	
EXAMINER: Th's certificate should be executed within 24 hours after death. If a certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, hould be forwarded to the Chief Medical Examiner's Office along with form 16s. Br. Page 3 should be used as a burial-transit permit. File pages 1 and 2 with signated agent, prior to burial, cremation, or removal, and any event within	20c. TIME DF INJURY Month, Oay, Year 20d. INJURY DCCURRED 20e. PLACE DF INJURY (Home, farm, Hour a.m. While p.m. 19 at work at work at work	nty) (State)
MATIN Id be Page nated	21. I certify that I took charge of the remains described above, held an Autopsy X, Inspection	and in my opinion
	death resulted from: Natural courses , Accident , Suicide , Homicide , Undetermined manner	
inte the your like the like th	ACTUAL SIGNATURE LA LECT LA LECT M.D. ASSISTANT MEDICAL EXAMINER	22. DATE SIGNED
TY MI exec Far i for th or	DEPUTY MEDICAL EXAMINER	A Filed
DEPUTY I Slease exe director. B etained fo FUNERAL of Health	23a. BURIAL CREMATION 23b DATE THERE JF 23c. NAME DE CEMETERY OR CREMATORY 23d. LDCATION (CITY, town or COL	pity / Wastate
Page po	CREMOVALY Specify 9-8-66 FULL day it toy Syllwille T. ADDRESS 250, RECISTRAR 250, REGISTRAR 250, REGISTRAR 250, REGISTRAR	SSIGNATURE
VR A15ME	24. FUNERAL DIRECTOR HAIL & ADDRESS 250. REGISTRAR	A Day Day Con
3500 4-64	The state of the s	= # # =

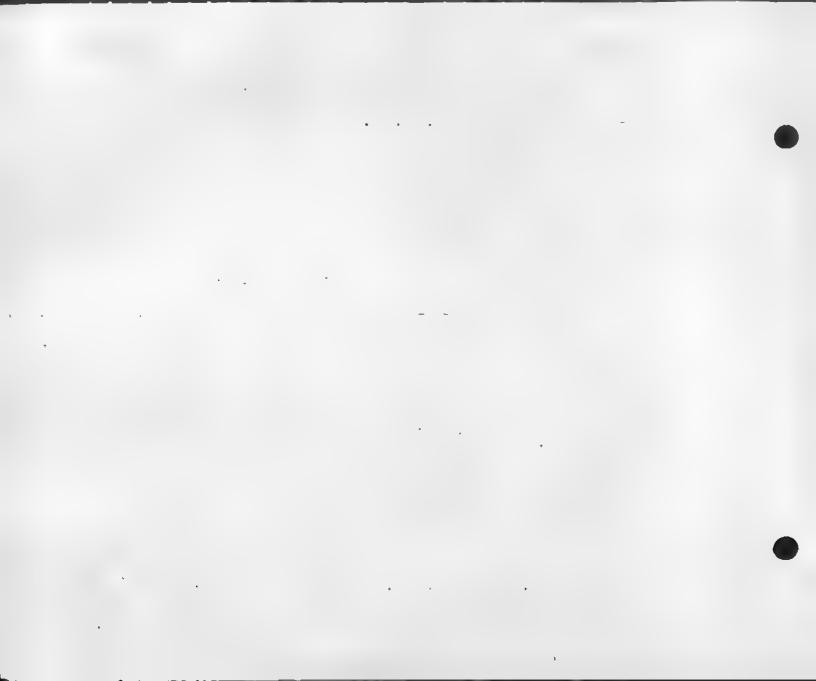


MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH funera I ond 2 ter death, 24 haurs after death. 2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) PLACE OF DEATH a. COUNTY b. COUNTY te y filled in by the function popers Pages I of within 72 hours after d Maryland Carroll MARYLAND CITY OR TOWN (If outside corporate firmits, write RURAL and a ve negrest town) h CITY OR TOWN 'I pulside to proofe limits. Rural -- Sykesville ly. 3m. 8d. Baltimore d NAME OF HOSPITAL OR INSTITUTION 'If not in hospital a ve street address) d. TREET ADDRESS e IS RESIDENCE ON A FARM? Springfield State Hospital Southern Avenue YES NO DC ATTENDING PHYSICIAN: The low requires that the death certificate be executed within rémove carbon 3 NAME OF 4 DATE Month Year complete y 0F DECEASED 19 1966 Mary Holmes and Im any event, (Type or print) Margaret DEATH B DATE OF BIRTH 9 AGE film years F UNDER 24 HRS 6 COLOR OR RACE 7 MARR ED NEVER MARRIED 85) birthdoy) Months Hours WIDOWED DIVORCED female ID6 KIND OF BUSINESS OR 12 CITIZEN OF WHAT 1Do USUAL OCC JPATION (Give kind of work done 11 BIRTHPLACE (County & State, or foreign country) during most of working life, even if retired) INDUSTRY COUNTRY? USA Maryland 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME or remavol, Margaret E. Green Balkmanac 15 WAS DECEASED EVER IN U.S. ARMED FORCES? 16 SOCIAL SECURITY NO 17 INFORMANT Address (Yes, no, or unknown) (If yes give wor or dates of service) 212-32-4025 Springfield Hospital records, Sykesville, Md. no burial, cremation, 18 CAUSE OF DEATH (Enter only one couse per line for (o), (b) and (c)) He TO FUNERAL DIRECTOR: After this certificate has been signed by the director, page 3 should be detached for use os the burial-transit should be filed with the State Dept. of Health prior to burial, cremati Weeks DEATH PART I DEATH WAS CAUSED BY: Bilateral pyelonephritis IMMEDIATE CAUSE (o) Poge 4 moy be retained by the hospital or ottending physicion. DUE TO Bronchopneumonia Conditions, fony which gove Days rise to immediate couse (o), **DUE TO** stating the underlying couse lost. PART I OTHER S GNIFICANT COND TONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART ICO.

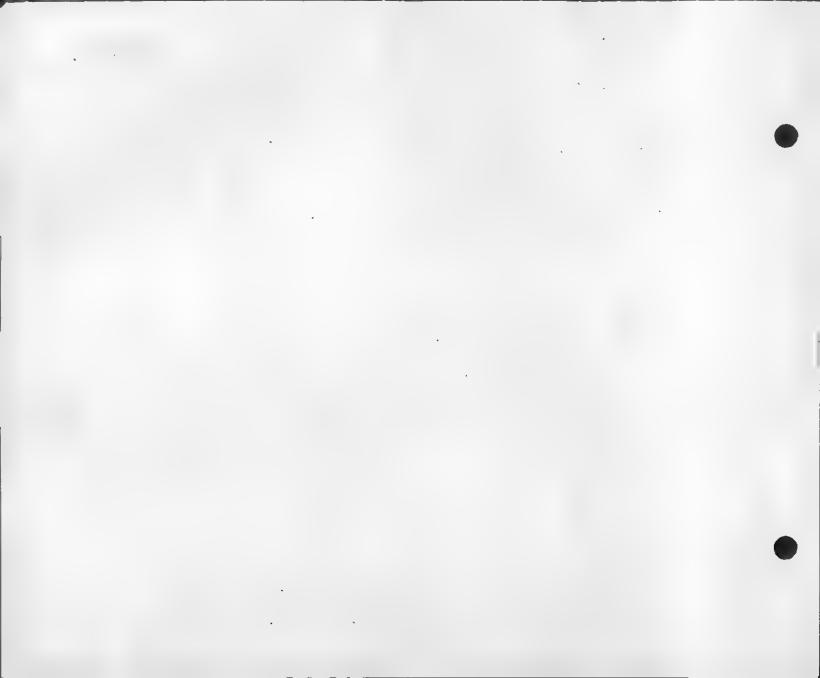
Chronic brain syndrome with senile brain disease without qualifying 19 WAS AUTOPSY PERFORMED? YES IX NO phrase. 2Do ACCIDENT WAS UNDERLYING 205 DESCRIBE HOW INJURY OCCURRED (Enter nature of njury in Port I or Port II of tem 18) OR CONTRIBUTING CAUSE OF DEATH LIF EITHER, NOTIFY MEDICAL EXAMINER 20e. PLACE OF INJURY (Home, form, 20c TIME OF INJURY Month, Day, Year 2Dd TNIJRY OCCURRED (City or town) (County) (State) Hour o.m. While Not While foctory, street, office bldg, etc.) of work ot work 9/19/ 1966 that P\$ (we) last 1965 ta 21. 1 certify that (this hospital) attended the deceased fram 6/11/ 19 66, and that death accurred at 2:30 PM, from causes and an the date stated above saw the deceased alive an 220. SIGNATURE 22b. DATE SIGNED ATTENDING M.D. DIRECTOR Springfield State Hospital 22c PHYSICIAN S 22d ADDRESS Naci N. Buyukunsak. NAME (Type)-Sykesville. Maryland 23c NAME OF CEMETERY OR CREMATORY 23b DATE THEREOF 23d LOCATION (City or Town) 23n BURIAL CREMATION (County) (Stote) REMOVAL (Spec fy) timore, REC D BY REGISTRAR 25b REG STRAR S SIGNATURE 24 FUNERAL DIRECTOR dar

Ruck, Inc Baltimore.

VR A15 (4) 20 M 1,66



MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH faled in by the funeral papers. Pages I and thin 72 haurs after degth gud 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) PLACE OF DEATH a COUNTY b COUNTY MARYLAND requires that the death certificate be executed within 24 haurs after b CITY OR TOWN (If c itside carporate limits, CLENGTH OF STAY IN 16 r CITY OR TOWN (If autside carporate limits, write RURAL and give nearest tawn) write RURAL and give negrest town) MINSTE "If not in hospital, give street address" d STREET ADDRESS event, within 72 ON A FARM YES NO X carbán 1 NAME OF 4 DATE Month DECEASED OF (Type ar print) DEATH IF UNDER 1 YEAR FUNDER 24 HRS SEX 6 COLOR OR RAC 7 MARRIED 9 AGE fin years NEVER MARRIED Manths DIVORCED WIDOWED physician and 10a. USUAL OCCUPATION (Give kind of work done 10b KIND OF BUSINESS OR 2 CITIZEN OF WHAT 1) B RTHPLACE (County & State, ar fareign country) INDUSTRY during rhost of working life, even if retired) Home HOUSEW. TE 13 FATHER'S NAME 14. MOTHER S MA.DEN NAME signea by the attending phy burial-transit permit. Then burial, crematian, ar remaver 110 MHS 15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, na, or unknown) ((If yes give war or dates of service)) 16 SOCIAL SECURITY NO 17 INFORMANT CAUSE OF DEATH (Enter only one cause per line for (a) INTERVAL BETWEEN PART I. DEATH WAS CAUSED BY. EREBRAL EMORRHAGE MMEDIATE CAUSE (a) Page 4 may be retained by the haspital ar attending physician. DUE TO ARDIOVASCULAR Canditions, if any, which gave rise to immediate cause (a), stating the underlying cause **TO FUNERAL DIRECTOR:** After this certificate has been directar, page 3 shauld be detached far use as the shauld be filed with the State Dept. of Health priar ta ISEASE last. PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(d) PERFORMED? MELLITUS YES [NO 205. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20a. ACCIDENT WAS UNDERLYING [OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY Month, Day, Year 20d INJURY OCCURRED 20e. PLACE OF INJURY (Hame, form, (City or town) (County) (State) Hour a.m. Not While factory, street, affice bldg., etc.) 9/12, 1966, that (1) (we) last 21. I certify that (I) (this haspital) attended the deceased from, . 1966 to 9/12 and that death accurred at 735 M, from causes and on the date stated above. 1966 saw the deceased alive an 220 SIGNATURE 22b DATE SIGNED ATTENDING M.D DIRECTOR 22d ADDRESS PHYSICIAN S NAME (Type) 10000 230 BURIAL, CREMATION DATE THEREOF NAME OF (EMETERY OR (REMATOR) (County) (State) REMOVAL (Specify) 24 FUNERAL DIRECTOR ADDRESS 25a RECO BY REGISTRAR 2Sb REGISTRAR'S SIGNATURE odei



MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND FOR STATE MEDICAL EXAMINER'S CERTIFICATE OF DEATH HEALTH DERT. 1. PLACE OF DEATH USUAL RESIDENCE (Where deceased lived, If institution? Residence before admission) a. STATE b. CDUNTY c. LENGTH DF STAY IN 16 . c. CITY DR TOWN (If outside corporate limits, write Rural and give nearest town) lay cessary, 13 to the funeral Page 5 may be b. CITY DR TDWN (if outside corporate limits, write RURAL and give nearest town) Reisterstown Westminster d. NAME DE HOSPITAL DR INSTITUTION (if not in hospital, give street address) d. STREET ADDRESS e. IS RESIDENCE DN A FARM? County Gen. Hospital ND X 3. NAME OF DECEASED (Type or print) AGE (In years | IF UNDER 1 YEAR | IF UNDER 24 HRS. DATE OF BIRTH 7. MARRIED THE NEVER MARRIED last birthdey) [Months | Days WIDOWED DIVDRCED 10a. USUAL DCCUPATION (Give kind of work done | 10b. KIND DF BUSINESS OR 12. CITIZEN DF WHAT 11. BIRTHPLACE (State or foreign country) CDUNTRY? during most of working life, even if retired) INDUSTRY U.S.A. Machine operator Congoleum-Nairm Maryland 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME Marshall E. Knight Bessie Thompson 15. WAS DECEASED EVER IN U.S. ARMED FORCES? , 16. SDCIAL SECURITY ND. | 17. INFORMANT (If yes give war or dates of service) EXAMINER: This certificate should be executed within the certificate, writing the word "pending" in pencil it should be forwarded to the Chief Medical Examiner's files. 219-36-0876 Mrs. Rose A. Knight Reisterstown 18. CAUSE OF DEATH [Enter only one cause per line for (a) (b), and (c) INTERVAL BETWEEN ONSET AND DEATH PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (6)_ Conditions. If eny, which gave rise to immediate DUE TO cause (a), stating the underlying cause last. 119. WAS AUTDPSY PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) PERFORMED? CERTIFICAT YES ND 7 DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury In Part I or Part II of Item 18.) 20a. EXTERNAL CAUSE WAS PRIMARY TO OF CONTRIBUTING CAUSE OF DEATH. 5.2 werute 3 shoul MEDICAL 20d. INJURY DCCURRED 120e. PLACE DF INJURY (Home, farm/) 20f. (City or town) (County) (State) 20c. TIME DF INJURY Month, Day, Year I factory, street, office bldg., etc.) - Not While 196 at work at work 21. I certify that I took charge of the remains described above, held an Autopsy Inspection 1-Inquiry . and in my opinion DIRECTOR: Undetermined manner death resulted from: Natural causes Accident 14: Suicide Homicide Page 4 sfor your 22. DATE SIGNED SIGNATURE FUNERAL I I LL I DEPUTY MEDICAL EXAMINER 17 director. retained 1 Address (Street, city, town, or county) NAME (Type) NAME OF CEMETERY OR CREMATORY 23d. LDCATION (City, town or county) 23a BURIAL CREMATION. 23h DATE THEREDE Patapsco Neth. Carroll Burial Cem Co 25a. REC'D BY REG STRAR | 25b. REGISTRAR'S 24. FUNERAL DIRECTOR Mills.



MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 3 0 5 0 6 CERTIFICATE OF DEATH requires that the deoth certificate be executed within 24 hours after death 2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission PLACE OF DEATH b COLNICarroll o. SWaryland " Carroll MARYLAND smpletely filled in by the vecarbon papers. Pages event, within 72 hours off c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) b CITY OR TOWN (floutside corporate imits, write RURAL and give nearest town) C LENGTH OF STAY IN 16 Manchester Westminster d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d STREET ADDRESS e IS RES DENCE 100 N. Main St. Carroll County General Hospital NO IX 3 NAME OF Middle 4 DATE Month Day completely Type or print) 0F WHELLIAM D. LAMBERT 19 66 DEATH 7. MARRIED TE IF UNDER 1 YEAR S SEX 6 COLOR OR RACE NEVER MARRED 8 DATE OF BIRTH 9 AGE (1 years lost birthday) Months Days DIVORCED 11/18/86 Male White MIDOWED IDa USUAL OCCUPATION Give kind of work done 10b KND OF BUSINESS OR 12 CITZEN OF WHAT 11 BIRTHPLACE 'County & State or foreign country) during most of working the even direttred) (N Committing Magistrate NDUSTRY COUNTRY? TISA Maryland 13. FATHER'S NAME 14 MOTHER'S MAIDEN NAME Sarah Shaffer William Lambert IS WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO 17. INFORMANT Address (Yes, no or unknown) (If yes a ve war or dates of service) 212-24-7324 Mrs. Gertie Lambert, Menchester, Md no INTERVAL BETWEEN 18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).) transit ONSET AND DEATH PART I DEATH WAS CAUSED BY: signed by the bur altrans burial, crem IMMEDIATE CAUSE (a) DUE TO Conditions, if ony, which gave nse to immediate cause (a). DUE TO stating the underlying cause O FUNERAL DIRECTOR: After this certificate has been director, page 3 should be detoched for use as the PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERM MAL DISEASE CONDITION GIVEN IN PART 1(a) 19 WAS AUTOPSY PERFORMED? NO 20a ACCIDENT WAS UNDERLYING . 205 DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c TIME OF N.JRY Month, Day, Year 20d INJURY OCCURRED 20e PLACE OF INJURY (Home, form, (City or town) (County) (State) Hour a.m. Not While factory, street, office bldg., etc.) at work at work 21. I certify that (1) (this has tol) attended the deceased from and 17, 1966, to Sept. 3, 1966, that (4) (we) lost Page 4 moy be retained sow the deceased of ve on 22/2. 2 1965, and that death occurred at 51/5 4M, from couses and on the date stated above. 22b. DATE SIGNED 22o. SIGNATURE Hut F. Jell M.D. DIRECTOR 22d. ADDRESS 22c. PHYSICIAN'S NAME (Type) 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d LOCATION (City or Town) 23a BURIAL CREMATION (County) (State) REMOVAL (Specify) Hampstead Md. 9/6/66 Hampstead Cemetery 1965 REGISTRARS SIGNATURED Burial 25a REC'D BY REG STRAR 24 FUNERAL DIRECTOR VR A15 (4) Tipton-Eline Hampstead. Md.



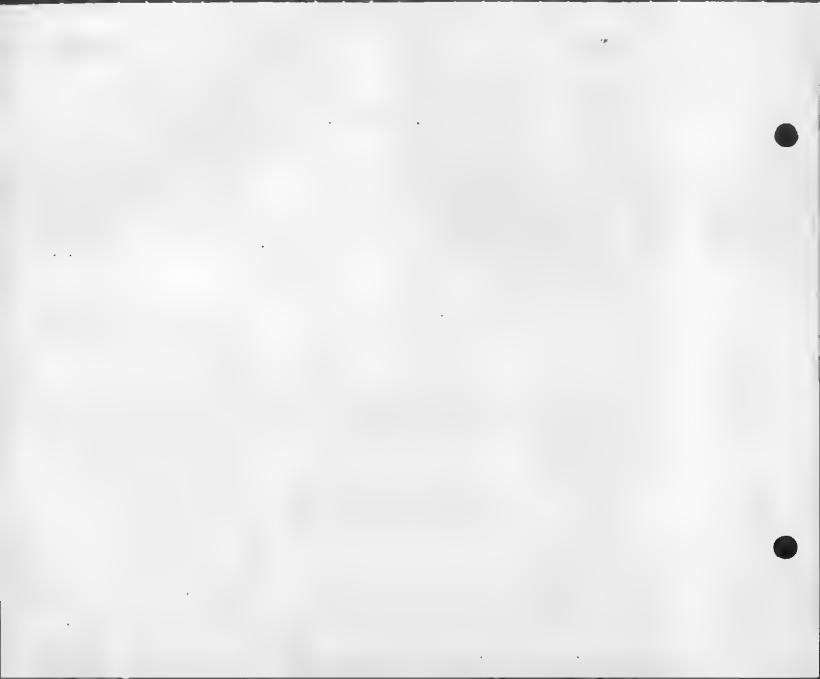
MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH executed within 24 hours after death funeral s 1 and 2 ter death 2 LSUAL RESIDENCE (Where deceased lived if institution Residence before admission) PLACE OF DEATH Baltimore City o. Maryland o COUNTY Carroll MARY, AND c CITY OR TOWN (If outside corporate mits write RURA, and give nearest town) b (ITY OR TOWN of outside corporate limits c LENGTH OF STAY IN 16 n and completely filled in by the se remove carbon papars. Page write RURAL and a ve nearest town) Baltimore dyrs.6mos.5dvs Sykesville S RESIDENCE d NAME OF HOSPITAL OR INSTITUTION (If not in hosp to lique street oddress) d STREET ADDRESS Springfield State Hospital 504 E. 34th St. YES NO 🏋 3 NAME OF Midd e 4 DATE Month Year DECEASED OF SEPTEM BER 26 66 JAMES ALBERT LAUTERBACH (Type or p int) F UNDER I YEAR 9 AGE 1 Years S SEX 6 COLOR OR RACE 7 MARRIED NEVER MARRIED DATE OF BRITH with the birthdoy) Months Doys Hours White Male DIVORCED WIDOWED 10b KIND OF BUS NESS OR 11 BiRTHPLACE (County & State or foreign country) 12 CITIZEN OF WHAT 100 _SUAL OCCUPATION (Give kind of work done law requires that the death certificate be puysician ar during most of working ife, even if retired)
None U.S.A. INDUSTRY Maryland 14 MOTHER'S MAIDEN NAME 13 FATHER S NAME or removal, signed by the attending Any burial-transit permit. Then burial, cremation, or remova John Henry Lauterbach Elizabeth Weber 15 WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes give wor or dotes of service) 17 INFORMANT OF YTIRLOGE ALONG AL Address Records, Springfield State Hospital 220-54-6905 INTERVAL BETWEEN 18. CAUSE OF DEATH (Enter on y one couse per ne for (a), (b), and (c).) ONSET AND DEATH PART I DEATH WAS CAUSED BY. IMMEDIATE (AJSE (o) Carcinoma of the bladder attending physicion DUE TO Conditions, if any, which gove) rise to immediate couse (o), er this certificate has been si a defached far use as the by ore Dept, of Health princes DUE TO stating the underlying couse () Bronchopneumonia with lung abscess Days PART III OTHER SIGNIFICANT CONDITIONS CONTR BUTING TO DEATH BUT NOT RELATED TO THE TERM NAT DISEASE CONDITION GIVEN IN PART HOW INCBS with diseases conditions due to prenatal constitutional influence with congenital cranial anomaly with behavioral reaction, with

The Action of the control of the congenitation of the control of the 19 WAS AUTOPSY PERFORMED? YES DIC NO the hospitol (IF EITHER, NOTIFY MEDICAL EXAMINER 20c I.ME OF INJURY Month, Doy, Year 20d INJURY OCCURRED 20e. PLACE OF INJRY (Home, form, (City or fown) (County) (Stote) O FUNERAL DIRECTOR: After this director, page 3 shaula be detact foctory, street, office bldg., etc.) Not While at work of work ond that death occurred of 8:30 9-26-66 , 19 , that (I) (we) last 21. I certify that (1) (this haspital) attended the deceased fram 3-21-60 to 9-26-66, 19__, that (I) (we) last Mr. from couses and on the date stated above 3 shaula be Page 4 may be retained 9-26-66 19 sow the deceosed olive on-22b. DATE SIGNED 22o SIGNATURE 9-27-66 director, page 3 should be filed v M D PHYS 22d ADDRESSSpringfield State Hospital 22c PHYSICIAN S NAME (Type) Sykesville, Maryland Octavio A. Ruiz, M. D. 23c NAME OF CEMETERY OR CREMATORY 23d LOCATION (City or Town) 23b DATE THEREOF 23a. BURIAL, CREMATION, REMOVAL (Spenify) Sept.29,1966 Mt. Carmel Cemetery Baltimore, Maryland 2So. REC'D BY REGISTRAR 2Sb. REGISTRAR'S SIGNATURE Wm. Cook-Brooks, Inc. 1217 St. Paul Street 2120 DATE S VR A15 (4) 20 M 1/66 Baltimore, Maryland



Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH and 2 2 USUAL RESIDENCE (Where deceosed lived, if institution. Residence before odmission) PLACE OF DEATH o COUNTY Carroll Maryland requires that the death certificate be executed within 24 haurs after MARYLAND Baltimore City c CTY OR TOWN (1 outside corporate limits, write RURAL and give nearest town) b CITY OR TOWN 'If outside corporate limits, t LENGTH OF STAY IN b Sykesville Baltimore 26vrs. Smos. 11dvs. d NAME OF HOSPITAL OR INSTITUTION (I not in hospital give street address) d STREET ADDRESS P S RESIDENCE ON A FARM? tampletely filled in 1500 Moreland Ave. Springfield State Hospital YES NO IX 3. NAME OF Middle 4 DATE Month DECEASED Type or pont) DAVID MMN LITTLE DEATH SEPTEMBER 6 COLOR OR RACE B DATE OF BIRTH F UNDER 24 HRS AGE In years 7 MARR FD NEVER MARR ED .lost birthdov) Hours Male White 10-19-01 WIDOWED DIVOR CED 100 ISJAL OCCUPATION (Give kind of work done 1Db KIND OF BUSINESS OR 12 C TIZEN OF WHAT 11 B RTHPLACE (County & Stote or foreign country) during must of wirking life even if refired,
Truck driver CO., NTRY 7 MDHSTRY Maryland
14 MOTHER'S MA DEN NAME U.S.A Albert Little Eva Barryman IS WAS DECEASED EVER IN U.S. ARMED FORCES? 17 INFORMANT 16 SOCIAL SECURITY NO Address (Yes, no, or unknown) (If yes give wor or dotes of service) Unk. Records, Springfield State Hospital 110nz 8 CAUSE OF DEATH (Enter on y one cause per line for (o), (b) and (c)) NTERVAL BETWEEN ONSET AND DEATH PART I DEATH WAS CAUSED BY. MMEDIATE CALSE (a) Mesenteric thrombosis DUE TO Conditions, if any, which gove rise to immediate couse (a), DUE TO has been s ise as the b ith priar tab storing the underlying couse PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERM NAL D SEASE CONDITION G VEN IN PART (o) 19 WAS AUTOPSY PERFORMED? Schizophrenic reaction, paranoid type NO X O FUNERAL DIRECTOR: After this certificate director, page 3 should be detached for us should be filed with the State Dept. of Healt 205 DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Port I or Port II of item 1B.) 20o. ACCIDENT WAS UNDERLYING [7] OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 2Dd. INJURY OCCURRED 2De. PLACE OF INJURY (Home, form, (City or town) 20c. TIME OF INJURY Month, Dov. Year (County) (Stote) Hour o.m. foctory, street, office bldg., etc.) Not While of work et work ATTENDING 21. I certify that (I) (this hospita) attended the deceased from 1-19-40 ____, 19____, that (1) (we) last 9-30-66 19 and that death occurred at saw the deceased alive an_ M. fram causes and an the date stated above. 22o SIGNATURE 27b DATE SIGNED MED. DIRECTOR ATTENDING 9-30-66 22d ADDRESS Springfield State Hospital 22c PHYSICIAN S Agustin del Campo. M. D. MAME (Type) Sykesville, Maryland 23o. BURIAL, CREMAT ON. 23b DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) (County) REMOVAL (Specify) Lorraine Park, emetery Baltimore, AD DRESS 250. REC D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE 24. FUNERAL DIRECTOR Milanley VR A15 (4) 4. Nuch Inc. Ballo. Ma. 21214 DATE Q C 20 M 1/66

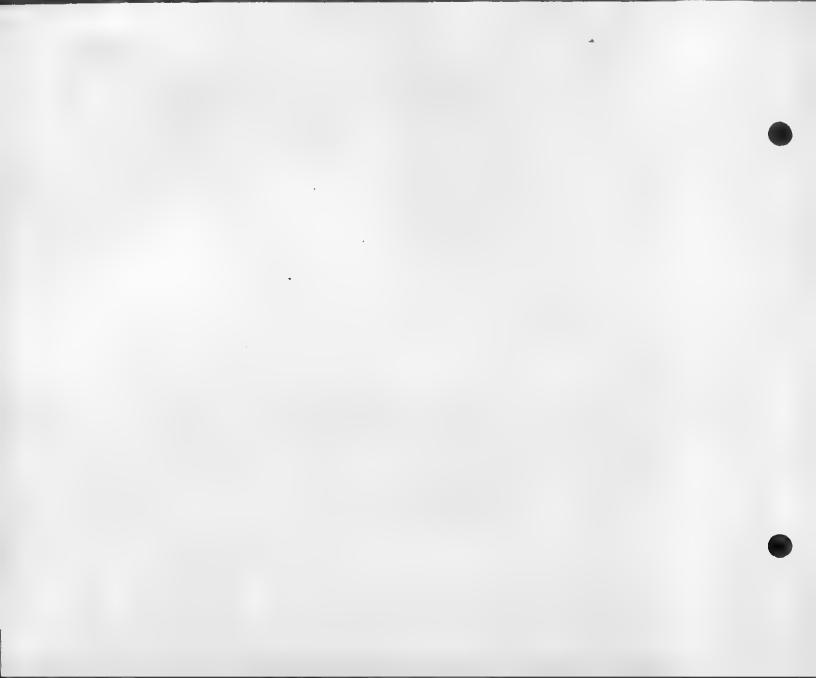
MARYLAND STATE DEPARTMENT OF HEALTH



MARYLAND STATE DEPARTMENT OF HEALTH OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH hours after death. 1. PLACE OF DEATH USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. COUNTY b. COUNTY d by the attending physician and completely filled in by the fransit permit. Then please remove carbon papers. Pages 1 cremation, or removel, and in any event, within 72 hours after MARYLAND b, CITY DR TOWN (if outside corporate limits, C. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) write RURAL and give nearest town) l. filled in I 1010 d. NAME OF HOSPITAL OR INSTITUTION (If not In hospital, give street address) d. STREET ADDRESS e. IS RESIDENCE ON A FARM? NO ATTENDING PHYSICIAN: The law requires that the death certificate be executed within retained by the hospital or attending physician. DATE OF DEATH NAME OF Month Middle DECEASED (Type or print) 19 5. SEX 6. COLOR OR RACE AGE (In years LIF UNDER 1 YEAR IF UNDER 24 HRS DATE OF 7. MARRIED NEVER MARRIED last birthday) | Months Days Hours 10a. USUAL OCCUPATION (Give kind of work done) 10b, KIND DF BUSINESS OR 12. CITIZEN OF WHAT & State, or foreign country) during most of working life, even if retired) INDUSTRY 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME Bank 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT Address (Yes, no, or unknwn) | (If yes give war or dates of service) INTERVAL BETWEEN 18. CAUSE OF DEATH [Enter only one cause per line for TO FUNERAL DIRECTOR: When this certificate has been signed by the director, page 3 should be detached for use as the burfal-transit should be filed with the State Dept. of Health prior to burfal, cremat ONSET AND DEATH PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUF TO Conditions, if any, which (b) gave rise to immediate DUE TO cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED WAS AUTOPSY CERTIFICATION PERFORMED? NO 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED, (Enter nature of injury in Part I or Part II of Item 18.) MEDICAL 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, (State) 20c. TIME OF INJURY Month, Day, Year 20f. (City or town) (County) factory, street, office bldg., etc.) Hour a.m. While Not While 19 at work at work be retained 21. I certify that (1) (this hospital) attended the deceased from 19.6 saw the deceased alive on and that death occurred at M, from the causes and on the date stated above. 22a. SIGNATURE 22b. DATE SIGNED! DIRECTOR M.D. PHYS. FO HOSPITAL (Page 4 may ADDRESS PHYSICIAN'S director, p NAME (Type) LOCATION (City, town or county) BURIAL, CREMATION, 2302 REMOVAL (Specify) ADDRE REGISTRAR'S SIGNATURE FUNERAL DIRECTOR REC'DL BY REGISTRAR VR A15 (4) 15M 4-64



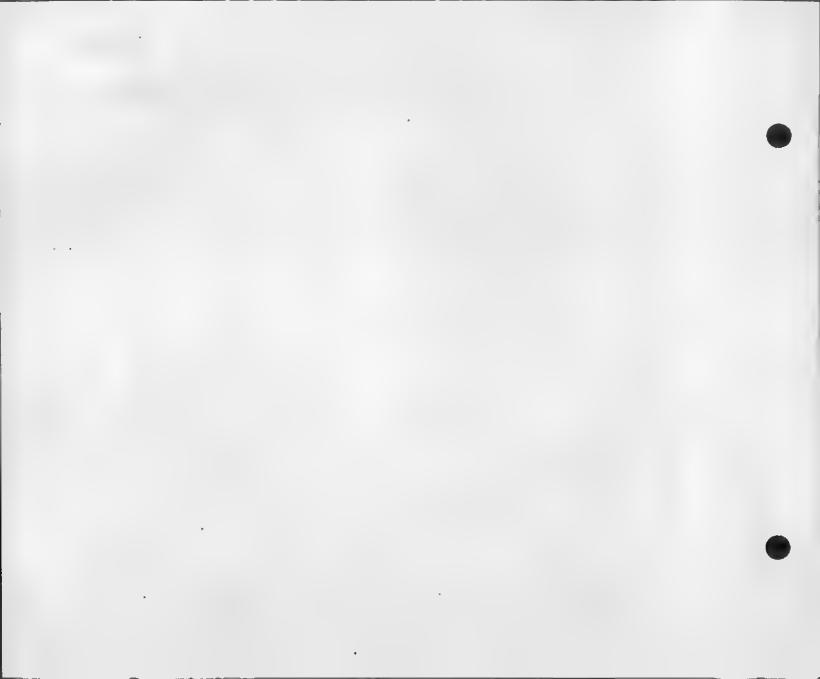
MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH ond 2 deoth, the death cert ficate be executed within 24 haurs after death I. PLACE OF DEATH 2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission o COUNTY 4 MARYLAND rutside comporate limits. C LENGTH OF STAY N ID (CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) BRIDGE d NAME OF HOSPITAL OR INSTITUTION (f not in hospital, give street oddress) d STREET ADDRESS e IS RESIDENCI ON A FARM? YES NO DE 4 DATE OF DEATH 3 NAME OF Middle First Month DECEASED (Type or print) S SEX FUNDER 1 YEAR 7 MARRIED NEVER MARR ED AGE In years last birthdoy) WIDOWED DIVORCED 10o US., AL OCCUPATION (Give kind of work done B RTHPLACE (County & State or foreign country) 12. CITIZEN OF WHAT during most of working life, even if retired) attending physician permit. Then please 13 FATHER'S NAME or removal. HESSON 17 INFORMANT Address cremation, CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).) signed by the burial-tronsit g PART I DEATH WAS CAUSED BY ONSET AND DEATH The law requires that IMMEDIATE CAUSE (o) Page 4 may be retained by the hospital or attending physician. DUE TO Conditions, if ony, which gove (b) rise to immediate couse (a). **DUE TO** stating the underlying couse as been a sthe prior to b has PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) 19. WAS AUTOPSY PERFORMED? certificate YES NO ٥ 200 ACCIDENT WAS UNDERLY NG 205 DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Port Lor Port II of Item 18.) OR CONTRIBUTING CAUSE OF DEATH detached (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c TIME OF INJURY Month, Day, Year 20d INJURY OCCURRED 20e PLACE OF INJURY (Home, form, (City or fown) (County) (Stote) Hour om foctory, street, office bidg, etc.) at work O FUNERAL DIRECTOR: After of work 21. I certify that (I) (this hospital) attended the deceased fram. 46, 19 that (1) (wer last saw the deceased alive an and that death accurred at X from causes and an the date stated above 22o. SIGNATURE 22b. DATE SIGNED MD PHYS DIRECTOR 22d ADDRESS director, pog should be file 22c PHYSICIAN'S NAME (Type) BURIAL CREMATION 23b DATE THEREO! NAME OF CEMETERY OR CREMATORY (County) (Stote) REMOVAL (Specify) 24 FUNERAL DIRECTOR ADDRESS 2So REC'D BY REG STRAR REG STRAR'S SIGNATURE DATE SED VR A15 (4) 20 M 1/66



MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH and 2 executed within 24 hours after death 2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) 1 PLACE OF DEATH Carroll b COUNTY Maryland MARYLAND Baltimore City b. CITY OR TOWN 4If a itside emporate limits C LENGTH OF STAY IN 16 c. CITY OR TOWN (If outside corporate limits, write RURA, and give nearest town) write RURAL and give nearest fown)
Sykesville 20 days Baltimore completely filled in b nove carbon papers by event, within 72 ha d STREET ADDRESS d NAME OF HOSP TAL OR INSTITUTION (If not in hospital, give street address) ON A FARM? 1458 N. Carey St. Springfield State Hospital YES NO X 3 NAME OF Middle 4 DATE Month DECEASED ST. DEATH WILLIAM JOHN SEPTEMBER 19 66 (Type or print) F UNDER 1 YEAR IF UNDER 24 HRS S SEX B DATE OF BIRTH AGE (In years 6 COLOR OR RACE 7 MARRIED NEVER MARRIED lost birthdoy) Months Dovs Hours 12-25-1892 X WIDOWED DIVORCED Male Negro physician and chen please remo remi IOH KIND OF BUSINESS OR 12 CIT ZEN OF WHAT , Do. USUAL OCCUPATION (Give k, ad of work done 11 BIRTHPLACE (County & State, or foreign country) law requires that the death cert ficate be and in COUNTRY? during most of working life, even if retired) INDUSTRY Virginia U.S.A Painter 14 MOTHER'S MAIDEN NAME 13. FATHER'S NAME effetding phys. removol, Charles W. Myers Elsie Smith 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no o unknown) (fyes give wor or dates of service) 16 SOCIAL SECURITY NO. 17. INFORMANT Address Records, Springfield State Hospital Unk. cremot.on, INTERVAL BETWEEN signed by the 6 burial-transit po burial, cremot.o 1B CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c).) ONSET AND DEATH PART I DEATH WAS CAUSED BY Mesenteric artery thrombosis IMMEDIATE CAUSE (o) DUE TO Conditions, if any, which gove Generalized arteriosclerosis Years rise to immediate couse (a) DUE TO offending p stating the underlying couse as the prior tal has been PART II, OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o) WAS AUTOPSY PERFORMED? for use Health p YES [NO X Page 4 may be retained by the hospital or O FUNERAL DIRECTOR: After this certificate 20b. DESCRIBE HOW INJURY OCCURRED (Enter noture of injury in Port I or Part II of Item 1B.) 200 ACC DENT WAS UNDERLY NG OR CONTRIBUTING CAUSE OF DEATH detached (IF EITHER, NOTIFY MEDICAL EXAMINER) MEDICAL 20d INJURY OCCURRED 20e PLACE OF INJURY (Home, form, (City or fown) (County) 20c. TIME OF .N. JRY Month, Doy, Year foctory, street, office bldg., etc.) Hour om. Not While ot work ot work þe 21. I certify that (1) (this haspital) attended the deceased from 8-18-66 . 19____, that (1) (we) ast saw the deceased alive on 9-8-66 Min fram causes and on the date stated above. 22b DATES GNED 22a SIGNATURE/ ATTENDING 9-8-66 DIRECTOR director, page 3 should be filed v M.D PHYS. 22d ADDRESS Springfield State Hospital 22c PHYSIC ANS Octavio A. Ruiz, M. NAME (Type) D. Sykesville, Maryland 23c NAME OF CEMETERY OR CREMATORY 23d LOCATION (City or Town) 230 BUR AL CREMATION 23b DATE THEREOI (County) (Stote) REMOVAL (Specify) Laltimore, Laryl 250 RECID BY REGISTRAR 25b REG STRARS SIGNATURE 24 FUNERAL DIRECTOR ADDRESS VR A15 (4) 20 M 1/66



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH funeral and 2 destri 1. PLACE DF DEATH USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. COUNTY **b. COUNTY** after by the ve carbon papers. Pages 1 event, within 72 hours after b. City or Town (if outside corporate limits, MARYLAND Manyland Balticore City
c. CITY On TOWN (If outside corporate limits, write RURAL and give nearest town) C. LENGTH OF STAY IN 15 write RURAL and give nearest town) hours Sykesville filled in mos. dys. Pal timore d. NAME DF HDSPITAL DR INSTITUTION (if not in hospita., give street address) d. STREET ADORESS e. IS RESIDENCE ON A FARM? S. ringfield State Hospital Cordelia Avenue YES ND 1 completely i executed within NAME OF Middle Last 4. DATE Year DECEASED DF DECO DEATH (Type or print) 1966 September and con remove any eve 6. COLOR OR RACE DATE OF BIRTH AGE (In years | IFUNDER 1 YEAR | IFUNDER 24 HRS. 7. MARRIED NEVER MARRIED last birthday) | Months | Days Hours 1 WIDDWED ermit. Then please re on, or removal, and in a lease re 10a. USUAL OCCUPATION (Give kind of workdone | 10b. KIND OF BUSINESS DR 11. BIRTHPLACE (County & State, or foreign country) 12. CITIZEN OF WHAT death certificate be during most of working life, even if retired) COUNTRY? West Virginia In eri r efcurator U.S.A. 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME Amelia Isace Westor If ther's name unknown in signed by the attend burial-transit permit. burial, cremation, or re 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 17. INFORMAN 16. SOCIAL SECURITY NO. (Yes, no, or unknwn) | (If yes give war or dates of service) Records, Springfield State Hos. ital No 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] INTERVAL BETWEEN TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by th director, page 3 should be detached for use as the burial-transit should be filed with the State Dept. of Health prior to burial, cremat ONSET AND DEATH PART I, DEATH WAS CAUSED BY: Bronchonneumonia ad/3 IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which Are riquelurguic cardiovascular discuse (b) gave rise to immediate DUE TO cause (a), stating underlying cause last, Generalizad arteriuscle.usis Vears CERTIFICATION PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) WAS AUTDPSY PERFORMED? YES K ND 20a. ACCIDENT WAS UNDERLYING TO OR CONTRIBUTING (T) CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part 1 or Part 11 of Item 18.) MEDICAL 20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 120e, PLACE OF INJURY (Home, farm, 20f. (City or town) (County) (State) factory, street, office bldg., etc.) Hour a.m. Not While at work at work 4-12-60 21. I certify that (I) (this hospital) attended the deceased from _, that (I) (we) last 7:40M, from the causes and on the date stated above. saw the deceased alive on and that death occurred at 22a. SIGNATURE 22b. DATE SIGNED ATTENDING M.D. PHYS DIRECTOR PHYS. PHYSICIAN'S 22d. ADDRESS Sta -NAME (Type) 23b. DATE THEREOF LOCATION (City, town or county) BURIAL, CREMATION. 23c. NAME OF CEMETERY OR CREMATORY REMDVAL (Specify) FUNERAL DIRECTOR REC'D BY REGISTRAR I Box 241, Sykesville, Ed. VR A15 (4) 4-64



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, 1 MARYLAND OF CERTIFICATE DEATH and 2 death hours after death PLACE OF DEATH USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. COUNTY b. COUNTY by the fur Pages 1 urs after b. CITY DR TOWN (If outside corporate limits, C. LENGTH OF STAY IN 1b c, CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) attending physician and completely filled in by rmit. Then please remove carbon papers. Pag n, or removal, and In any event, within 72 hours ,30x 38 Box d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) e. IS RESIDENCE ON A FARM? NO P YES PHYSICIAN: The law requires that the death certificate be executed within the hospital or attending physician. NAME DE Middle Last DATE Month Year DF DEATH (Type or print) 196 AGE (In years | IF UNDER 1 YEAR | IF UNDER 24 HRS 8. DATE OF BIRTH NEVER MARRIED last birthday) Months WIDOWED DIVORCED [10a. USUAL OCCUPATION (Give kind of work done | 10b. KIND OF BUSINESS OR 12. CITIZEN OF WHAT 11. BIRTHPLACE (County & State, or foreign country) during most of working life, even if retired) INDUSTRY 13. FATHER'S NAME WIFE 15. WAS DECEASED EVER IN U.S. ARMED FORCES? been signed by the attend the burial-transit permit. or to burial, cremation, or re 16. SOCIAL SECURITY NO. 17. INFORMANT (Yes, no, or unknown) (If yes give war or dates of service) 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] ONSET AND DEATH PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a DUE TO ARNERIOSCLEROSIS Conditions, if any, which TO HOSPITAL OR ATTENDED. The hospital of Page 4 may be retained by the hospital of the To FunkRAL DIRECTOR. After this certificate has been director, page 3 should be detached for use as the beautiful be filed with the State Dept. of Health prior to be a state of the filed with the State Dept. gave rise to immediate DUE TO cause (a), stating underlying cause last (c) CERTIFICATION PART II, DIBER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) WAS AUTDPSY PERFORMED? YES . NO 20a, ACCIDENT WAS UNDERLYING [] OR CONTRIBUTING [] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part | or Part | of Item 18.) MEDICAL TIME OF INJURY Month, Day, Year 20d, INJURY OCCURRED 120e, PLACE OF INJURY (Home, farm, 20f. (City or town) (County) (State) factory, street, office bldg., etc.) Hour a.m. While Not While at work at work 21. I certify that (I) (this hospital) attended the deceased from. and that death occurred at 9:70 M. from the causes and on the date stated above. saw the deceased alive on 1966 22a, SIGNATURE DIRECTOR M.D. PHYS. PHYSICIAN'S 22d. ADDRESS NAME OF CEMETERY OR CREMATORY BURIAL, CREMATION. FUERGREEN MEM, GARDENS FUNERAL DIRECTOR REC'D BY REGISTRAR REGISTRAR'S SIGNATURE VR A15 (4) DATE 15M 4-64



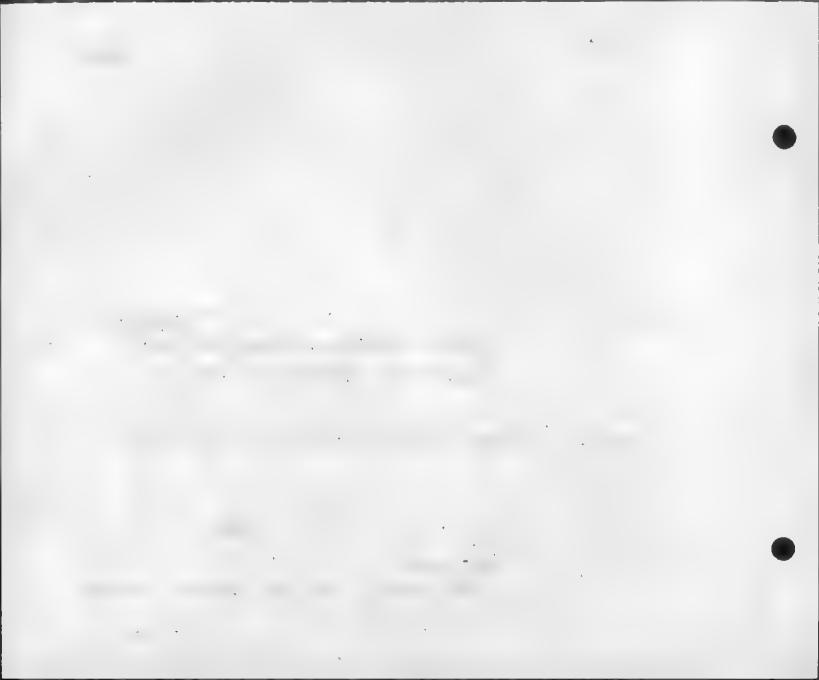
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, If institution, Residence before admit a. STATE MARYLAND b. COUNTY ARROLD b. COUNTY BRIDGE b. COUNTY B. STATEST B. COUNTY BRIDGE b. COUNTY B. STATEST B. COUNTY B	DENCE ARM? O X HRS.
CERTIFICATE OF DEATH 1. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, It institution, Residence before admit a. COUNTY ARPLAND b. COUNTY ARPLAND b. COUNTY ARPLAND c. LENGTH OF STAY IN 16 write RURAL and gave nesered lown WEARS d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital), give street address d. NAME OF DECEASED d. NAME OF DECEASED Type or print) 1. PLACE OF DEATH a. COUNTY ARRYLAND b. COUNTY ARRYLAND c. LENGTH OF STAY IN 16 write RURAL and give nearest lown WEARS d. STREET ADDRESS G. STREET ADD	DENCE ARM? O X HRS.
b CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) write RURAL and give nearest town WEARS IN AME OF HOSPITAL OR INSTITUTION (if not in hospital), give street address d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital), give street address A. NAME OF HOSPITAL OR INSTITUTION (if not in hospital), give street address J. NAME OF HOSPITAL OR INSTITUTION (if not in hospital), give street address J. NAME OF HOSPITAL OR INSTITUTION (if not in hospital), give street address J. NAME OF HOSPITAL OR INSTITUTION (if not in hospital), give street address J. NAME OF HOSPITAL OR INSTITUTION (if not in hospital), give street address J. NAME OF HOSPITAL OR INSTITUTION (if not in hospital), give street address J. NAME OF HOSPITAL OR INSTITUTION (if not in hospital), give street address J. NAME OF HOSPITAL OR INSTITUTION (if not in hospital), give street address J. NAME OF HOSPITAL OR INSTITUTION (if not in hospital), give street address J. NAME OF HOSPITAL OR INSTITUTION (if not in hospital), give street address J. NAME OF HOSPITAL OR INSTITUTION (if not in hospital), give street address J. NAME OF HOSPITAL OR INSTITUTION (if not in hospital), give street address J. NAME OF HOSPITAL OR INSTITUTION (if not in hospital), give street address J. NAME OF HOSPITAL OR INSTITUTION (if not in hospital), give street address J. NAME OF HOSPITAL OR INSTITUTION (if not in hospital), give street address J. NAME OF HOSPITAL OR INSTITUTION (if not in hospital), give street address J. NAME OF HOSPITAL OR INSTITUTION (if not in hospital), give street address J. NAME OF HOSPITAL OR INSTITUTION (if not in hospital), give street address J. NAME OF HOSPITAL OR INSTITUTION (if not in hospital), give street address J. NAME OF HOSPITAL OR INSTITUTION (if not in hospital), give street address J. NAME OF HOSPITAL OR INSTITUTION (if not in hospital), give street address J. NAME OF HOSPITAL OR INSTITUTION (if not in hospital), give street address J. NAME OF HOSPITAL OR INSTITUTION (if not in hospit	DENCE ARM? O X HRS.
b CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) write RURAL and give nearest town WEARS IN AME OF HOSPITAL OR INSTITUTION (if not in hospital), give street address d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital), give street address A. NAME OF HOSPITAL OR INSTITUTION (if not in hospital), give street address J. NAME OF HOSPITAL OR INSTITUTION (if not in hospital), give street address J. NAME OF HOSPITAL OR INSTITUTION (if not in hospital), give street address J. NAME OF HOSPITAL OR INSTITUTION (if not in hospital), give street address J. NAME OF HOSPITAL OR INSTITUTION (if not in hospital), give street address J. NAME OF HOSPITAL OR INSTITUTION (if not in hospital), give street address J. NAME OF HOSPITAL OR INSTITUTION (if not in hospital), give street address J. NAME OF HOSPITAL OR INSTITUTION (if not in hospital), give street address J. NAME OF HOSPITAL OR INSTITUTION (if not in hospital), give street address J. NAME OF HOSPITAL OR INSTITUTION (if not in hospital), give street address J. NAME OF HOSPITAL OR INSTITUTION (if not in hospital), give street address J. NAME OF HOSPITAL OR INSTITUTION (if not in hospital), give street address J. NAME OF HOSPITAL OR INSTITUTION (if not in hospital), give street address J. NAME OF HOSPITAL OR INSTITUTION (if not in hospital), give street address J. NAME OF HOSPITAL OR INSTITUTION (if not in hospital), give street address J. NAME OF HOSPITAL OR INSTITUTION (if not in hospital), give street address J. NAME OF HOSPITAL OR INSTITUTION (if not in hospital), give street address J. NAME OF HOSPITAL OR INSTITUTION (if not in hospital), give street address J. NAME OF HOSPITAL OR INSTITUTION (if not in hospital), give street address J. NAME OF HOSPITAL OR INSTITUTION (if not in hospital), give street address J. NAME OF HOSPITAL OR INSTITUTION (if not in hospital), give street address J. NAME OF HOSPITAL OR INSTITUTION (if not in hospital), give street address J. NAME OF HOSPITAL OR INSTITUTION (if not in hospit	DENCE ARM? O X HRS.
Description of the state of the	HRS.
Write RURAL and cave peacest lown) Write Rural and cave peacest l	HRS.
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address FARQLHAR FESTON ON AFA YES ON OF DECEASED (Type or print) LILLIE Months Day FARGE (In years IF UNDER 14 FAR IF UNDER 24 IF DECEASED TO DEC	HRS.
FARQUHAR ST YES NO NO A FA YES NO NO A FA YES NO NO NAME OF DECEASED (Type or print) S. SEX O COLOR OR RACE 7. MARRIED NEVER MARRIED B DATE OF BRTH O WIDOWED DIVORCED AUG-11, 1879 TO DEATH SEPT 2 19 4. SEX ON A FA YES NO NO NAME OF DECEASED (Type or print) S. SEX O COLOR OR RACE 7. MARRIED NEVER MARRIED B DATE OF BRTH O WIDOWED DIVORCED AUG-11, 1879 TO DEATH SEPT 100. USUAL OCCUPAT ON (G ve land of work 1Db KIND OF BUS.NESS OR INDUSTRY 1) B OTHPLACE County & State or foreign country 100. USUAL OCCUPAT ON (G ve land of work 1Db KIND OF BUS.NESS OR INDUSTRY 1) B OTHPLACE County & State or foreign country 113. FATHER'S NAME WILLIAM FRITZ ELLA FRITZ HAD ON A FA YES NO OF DECEASED (Type or print) 19 4. DECEASED 19 4. 10 B OTHPLACE Country & State or foreign country 12. CITIZEN OF WHAT COUNTRY AND 13. FATHER'S NAME WILLIAM FRITZ ELLA FRITZ HAD WILLIAM FRITZ HAD ON A FA YES NO OF DECEASED 19 4. DATE OF BRTH 9 AGE (In years IF UNDER 1 YEAR IF UNDER 24 IF HOUSE MONTHS MONTHS NO ON A FA YES NO OF DECEASED 19 4. DATE OF BRTH 9 AGE (In years IF UNDER 1 YEAR IF UNDER 24 IF HOUSE AND ON A FA YES NO OF DECEASED 19 4. DATE OF BRTH 9 AGE (In years IF UNDER 1 YEAR IF UNDER 24 IF HOUSE NO OF DECEASED 19 4. DATE OF BRTH 9 AGE (In years IF UNDER 1 YEAR IF UNDER 24 IF HOUSE OF DECEASED 19 4. DATE OF BRTH 9 AGE (In years IF UNDER 1 YEAR IF UNDER 24 IF HOUSE AND OF DECEASED 19 4. DATE OF BRTH 9 AGE (In years IF UNDER 1 YEAR IF UNDER 24 IF HOUSE AND OF DECEASED 19 4. DATE OF BRTH 9 AGE (In years IF UNDER 1 YEAR IF UNDER 24 IF HOUSE O COLOR OF THE SERVER 19 4. DATE OF BRTH 9 AGE (In years IF UNDER 1 YEAR IN UNDER 24 IF HOUSE 10 4. DATE OF THE SENT IN UNDER 24 IF 10 A COLOR OF THE SERVER 10 A COLOR OF THE SERVER	HRS.
A. DATE Month Day Year DECEASED (Type or print) S. NAME OF DECEASED (Type or print) S. SEX 6 COLOR OR RACE 7. MARRIED NEVER MARRIED B DATE OF BRTH WIDOWED DIVORCED AUG-11, 1879 S. SEX 6 COLOR OR RACE 7. MARRIED NEVER MARRIED B DATE OF BRTH WIDOWED DIVORCED AUG-11, 1879 S. SEX 6 COLOR OR RACE 7. MARRIED NEVER MARRIED B DATE OF BRTH WIDOWED DIVORCED AUG-11, 1879 S. SEX 6 COLOR OR RACE 7. MARRIED NEVER MARRIED B DATE OF BRTH F WIDOWED DIVORCED AUG-11, 1879 S. SEX 6 COLOR OR RACE 7. MARRIED NEVER MARRIED B DATE OF BRTH F WIDOWED DIVORCED AUG-11, 1879 S. SEX 6 COLOR OR RACE 7. MARRIED NEVER MARRIED B DATE OF BRTH F WIDOWED DIVORCED AUG-11, 1879 S. SEX 6 COLOR OR RACE 7. MARRIED NEVER MARRIED B DATE OF BRTH F WIDOWED DIVORCED AUG-11, 1879 S. SEX 6 COLOR OR RACE 7. MARRIED NEVER MARRIED B DATE OF BRTH F WIDOWED DIVORCED AUG-11, 1879 S. SEX 6 COLOR OR RACE 7. MARRIED NEVER MARRIED B DATE OF BRTH F WIDOWED DIVORCED AUG-11, 1879 S. SEX 6 COLOR OR RACE 7. MARRIED NEVER MARRIED B DATE OF BRTH F WIDOWED DIVORCED AUG-11, 1879 S. SEX 6 COLOR OR RACE 7. MARRIED NEVER MARRIED B DATE OF BRTH F WIDOWED DIVORCED AUG-11, 1879 S. SEX 6 COLOR OR RACE 7. MARRIED NEVER MARRIED B DATE OF BRTH F WIDOWED DIVORCED AUG-11, 1879 S. SEX 6 COLOR OR RACE 7. MARRIED NEVER MARRIED B DATE OF BRTH F WIDOWED DIVORCED AUG-11, 1879 S. SEX 6 COLOR OR RACE 7. MARRIED DATE OF BRTH F WIDOWED DIVORCED AUG-11, 1879 S. SEX 6 COLOR OR RACE 7. MARRIED DATE OF BRTH F WIDOWED DIVORCED AUG-11, 1879 S. SEX 6 COLOR OR RACE 7. MARRIED DATE OF BRTH F WIDOWED DIVORCED AUG-11, 1879 S. SEX 6 COLOR OR RACE 7. MARRIED DATE OF BRTH F WIDOWED DATE OF BRTH F WIDO	HRS.
DECEMBED (Type or print) L/L/E. MAY OTTO DEATH SEPT 2/ 19 4 5. SEX 6 COLOR OR RACE 7. MARRIED NEVER MARRIED B DATE OF BRTH WIDOWED DIVORCED DIVORCED NOT HOUSE MAINTING COUNTY WIDOWED DIVORCED NOT HOUSE MAINTING THE PRINT OF WHAT COUNTY WIDOWED DIVORCED NOT HOUSE MAINTING THE PRINT OF WHAT COUNTY WIDOWED DIVORCED NOT HOUSE MAINTING THE PRINT OF WHAT COUNTY WIDOWED DIVORCED NOT HOUSE WIFE OWN HOME MARRIED DEATH SEPT DIVORCED	HRS.
5. SEX 6 COLOR OR RACE 7. MARRIED NEVER MARRIED B DATE OF BRTH 9 AGE (In years IF UNDER 1 YEAR IF UNDER 24 IF UNDER 24 IF UNDER 1 YEAR IF UNDER 24 I	Ain.
WIDOWED NOTIFE OWN HOME MAKED AUGIN, 1879 San Distribution of Months Days Hours M. WIDOWED NOTIFE OWN HOME MAKED AUGIN, 1879 San Distribution of Months Days Hours M. Hours M. Single or foreign country 12. CITIZEN OF WHAT COUNTRY OF MAKED AUGIN MONTHS Days Hours M.	Ain.
WIDOWED DIVORCED MUG-1, 1877 8 yrs 10a. USUAL OCCUPAT ON (G ve kind of work 10b. KIND OF BUS.NESS OR INDUSTRY 1) B 9THPLACE County & State or love.gn country 12. CITIZEN OF WHAT COUNTRY 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME WILLIAM FRITZ ELLA FRITZ HAD WIDOWED DIVORCED MUG-1, 1877 8 yrs 10a. USUAL OCCUPAT ON (G ve kind of work done during spot of working life, even if refired) 12. CITIZEN OF WHAT COUNTRY 13. FATHER'S NAME WILLIAM FRITZ ELLA FRITZ HAD WILLIAM FRITZ WILLIAM FRITZ HAD WILLIAM FRITZ WILLIAM F	MIN.
10a. USUAL OCCUPATION (Give kind of work and of work and of work done during most of working life, even if relired) 10a. USUAL OCCUPATION (Give kind of work and of work and of work and of working life, even if relired) 10a. USUAL OCCUPATION (Give kind of work and of work and of work and of working life, even if relired) 10a. USUAL OCCUPATION (Give kind of work and of work	NTRY?
WILLIAM FRITZ ELLA FRITZ	
WILLIAM FRITZ ELLA FRITZ	
The state of the s	
The state of the s	
(Yes no or unknown) (()) vergive warproduler of service	-
(Yes, no, or unknown) (Hyesgivewarordales of service, 2/8 5/2-10/1 140 DO DO DET RING HOOT 1/01, ADI PRINT	<u>_</u>
118. CAUSE OF DEATH [Enter only one cause per line for (a) the and to	
ONSET AND DEAT	
PART I, DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PRIN and Cigal of there sclerosis One to	
Pue To	
Conditions, if any, which \ (b)	
oave rise to immediate cause	
(a), stating the underlying DJE TO	
Cause leat. (c)	70¢V
PERFORME PERFORME	ED?
Piat & b & My Dostatic (Newmona" 185 No	
20a. ACCIDENT WAS UNDERLYING 20b. DESCR BE HOW NJURY OCCURED, (Enter nature of injury in Part or Part II of Item 1B.)	
목으로 을 B (of Either, Notify Medical Extantier)	
Up 5 5 7 7 20c, TIME OF INJURY Month, Day, Year 20d, INJURY OCCURRED 2De, PLACE OF INJURY (Home, tarm., 201. (City or lown) (County) (State	te)
20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 2De. PLACE OF INJURY (Home, farm. 20l. (City or lown) (County) (State of the county) (State of t	
21. I certify that (I) (this hospital) attended the deceased from 19 19) last
saw the deceased alive on. 9/20/66 19, and thut death occurred a AMM, from the causes and on the date stated about	ove.
ATTENDING MED. STAFF	ATE
MD PHYS DIRECTOR PHYS - 9/21/60	L
22d. ADDRESS	
22c. PHYSICIALS 22d. ADDRÉSS UNION BRIDGE 23d. BURIAL, CREMATION, 23b. DATE THEREOF 23d. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City, town or county) (State)	
23a, BURIAL, CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City, town or county) (State)	
DUNING 1187120 11811100131	
VR AIS 140- 24 FUNERAL DIRECTOR'S SIGNATURE ADDRESS 252, REC'D BY REGISTRAR 256 REGISTRAR'S SIGNATURE	
15M 7-62 & DATE OF HARLET I Stone Union Dridge DATE DEP DE	



MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH by the funeral Pages 1 and 2 naurs after death. 0 24 hours after death. 2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) PLACE OF DEATH a county Maryland Allegany MARYLAND c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CLENGTH OF STAY N 1b b City OR TOWN (If outside corporate muts Sykesville Cumberland 2mos.22dvs. d STREET ADDRESS e S RES DENCE ON A FARM? d NAME OF HOSPITAL OR INSTITUTION If not in hospital, give street address) Frederick St. Springfield State Hospital YES . NO 💢 OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within Middle 4 DATE pau 3 NAME OF Month Day campletely OF DECEASED BESSIE PEARL PARSOUDIS SEPTE BER (Type or print) DEATH IF LINDER 1 YEAR IF UNDER 24 HRS AGE 5 SEX 6 COLOR OR RACE 7 MARRIED NEVER MARRIED 8 DATE OF BIRTH n years Tremave Jost birthdoy) Months Dovs Hours 8-14-1893 Female White DIVORCED WIDOWED physician and c 10b K NO OF BUSINESS OR 12 CITIZEN OF WHAT 100 USUAL OCCUPATION Give kind of work done 11 BIRTHPLACE (County & State, or fare gn country) please 1 COUNTRY? INDUSTRY during most of working life, even if retired) U.S.A Maryland Housewife 14 MOTHER'S MA DEN NAME 13 FATHER'S NAME remayak Sarah Robertson Peter Twigg attenming p 16 SOCIAL SECURITY NO. 17. INFORMANT Address 15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give wor or dates of service) Ö Hone Records, Springfield State Hospital No crematian, INTERVAL BETWEEN 18 CAUSE OF DEATH (Enter only one cause per line for (o), (b), and (c)) signed by the burial-transit s 투 ONSET AND DEATH PART I DEATH WAS CAUSED BY Congestive heart failure Days IMMEDIATE CAUSE (o) attending physician. DUE TO Conditions, if any, which gave Arteriosclerotic heart disease Years rise to immed ate cause (a) DUE TO Years stating the underlying couse as the priartat hos been Generalized arteriosclerosis. Diabetes mellitus Years 19 WAS AUTOPSY PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERM NAU DISEASE CONDITION GIVEN IN PART 1601 PERFORMED? for use Health p CERTIF CATION YES [NO TO FUNITAL DIRECTOR: After this certificate director, page 3 shauld be detached for us shauld be filed with the State Dept. of Healt TO HOSPITAL OR ATTENDING PHYSICIAN: 'Page 4 may be retained by the haspital ar 205. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part or Part II of item 18.) 200 ACCIDENT WAS UNDERLY NG OR CONTRIBUTING CAUSE OF DEATH (IF FITHER, NOTIFY MEDICAL EXAMINER MEDICAL 20e PLACE OF IN. JRY (Home, form, (City or fown) (Stote) TIME OF INJURY Month, Day, Year 20d INJURY OCCURRED (County) factory, street, office bldg., etc.) Hour o.m. Not While at work 21. I certify that (1) (this hospital) attended the deceased from. 19____, that (I) (we) lost , and that death accurred at 11: 33M. From causes and on the date stated above. 9-7-66 19 sow the deceased alive on. 22b. DATE 5 GNED 220 SIGNATURE 9-7-66 PHYS 22d ADDRESS Springfield State Hospital 22c PHYSICIAN S NAME (Type) Agustin del D. Campor M. Sykesyille Maryland 23c NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) 236 DATE THEREOF (County) 23a BURIA. CREMAT ON (Stote) REMOVAL (Specify) 9/10/65 'e rerial Park e wis serilli. rue jan't 25g REC D BY REGISTRAR Annress 25b REGISTRAR'S SIGNATURE 24 FUNERAL DIRECTOR VR A15 (4) Current ort. J. Walle 20 M 1766

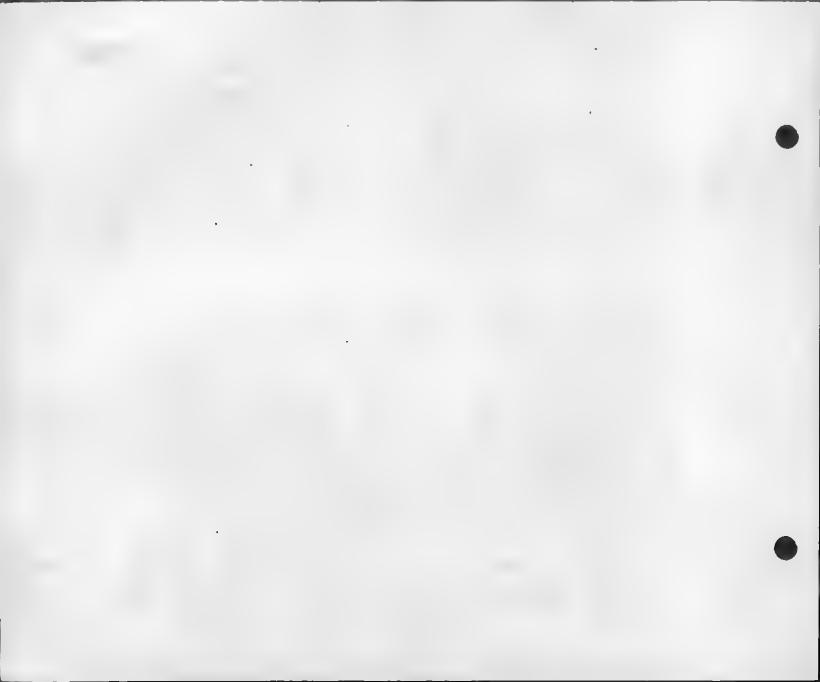


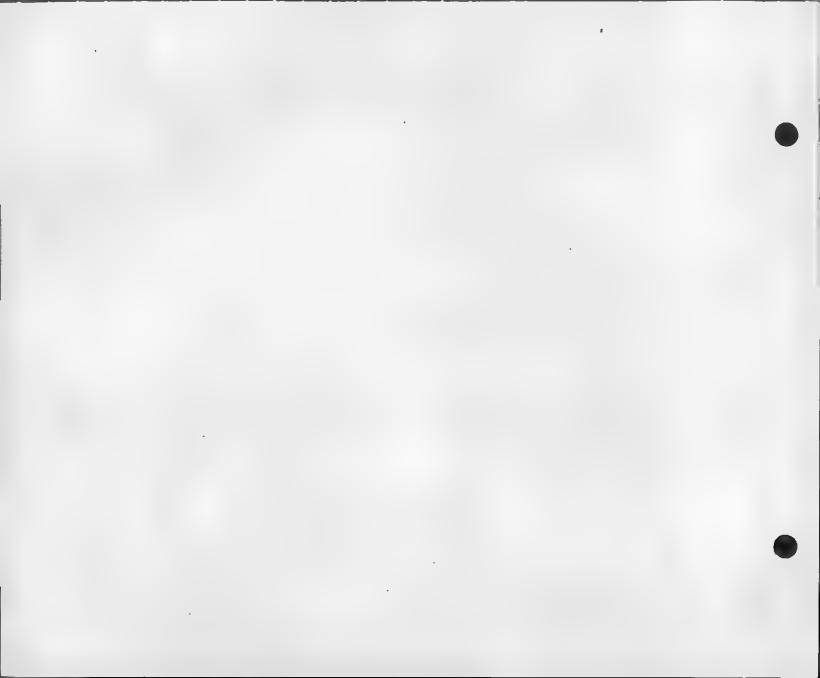
MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH 24 hours after death 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) funeral PLACE OF DEATH " Carrol Maryland MARYLAND b CITY OR TOWN (If outside carparate limits, C LENGTH OF STAY N 1b c CITY OR TOWN (If outs de corporate limits, write RURAL and give nearest town) write RURAL and give nearest town? Rural - Hampstead Westminster d STREET ADDRESS d NAME OF HOSP TALLOR INSTITUTION (If not in haspital, give street address) ON A FARM? Grace Road Carroll County General Hospital YES IN NO F 4 DATE 3 NAME OF M ddle Manth 1966 DECEASED HOWARD PEREGOY G. Type or printi S SEX 6 COLOR OR RACE 7 MARR ED B DATE OF BIRTH 9 AGE (In years F UNDER I YEAR FUNDER 24 HRS NEVER MARRIED F remove lost birthday! Manths Hours White Male W DOWED 10a USUALOCC PAT ON Give kind of work done 10b, KIND OF BUSINESS OR 12 CT ZEN OF WHAT 11 B RTHPLACE (County & State or fare an country) during most of warking life even if retired) INDUSTRY now physicion Marvland requires that the death refilitheate 14 MOTHER'S MAIDEN NAME 13 FATHER'S NAME or removal, Emma Jane Zouck Elijah Peregoy 15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, na, or unknown) (If yes give wor ar dates of service) 16 SOCIAL SECUR TY NO 17 INFORMANT Address permit. Mrs. Jessie Peregoy, Hampstead, Md. signed by the after bur, al-transit permi burial, tremation, a INTERVAL BETWEEN IB. CAUSE OF DEATH (Enter only one cause pt) line for (a) (b), and yt) PART I, DEATH WAS CAUSED BY: IMMEDIATE CAUSE (of Conditions, if any which gave rise to immediate couse (a), stating the underlying cause etached for use as the Dept. of Hearth prior to last PARTUM OTHER'S GNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINA, DISEASE CONDITION GIVEN IN PARTUTO WAS AUTOPSY PERFORMED? O FUNERAL DIRECTOR: After this certificate 20g ACC DENT WAS UNDERLYING 205 DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I ar Pack of item 18) OR CONTRIBUTING [CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER 20d INJURY OCCURRED 20e PLACE OF INJURY (Hame, farm, (City or town) (County) 20c TIME OF INJURY Month, Day Year (State) factory, street, office plda . etc.) Not While at wark certify that (I) (this has noted) attended the decreased from director, page 3 shauld should be filed with the 1966 and that death accurred At 45A M, fram causes and an the date stated above. he deceased alive an SIGNATUR DIRECTOR 22d PHYSICIAN DATE THEREOF NAME OF CEMETERY OR CREMATORY 23d LOCATION (City or Town) 9/5/66 Carmel Cometery Balto. Co. 24 FLINERAL DIRECTOR 25g RECD BY REGISTRAR 25b REGISTRAR'S SIGNATURE Travelly VR A15 (4) Tipton-Eline Hampstead. Md. 20 M 1/66



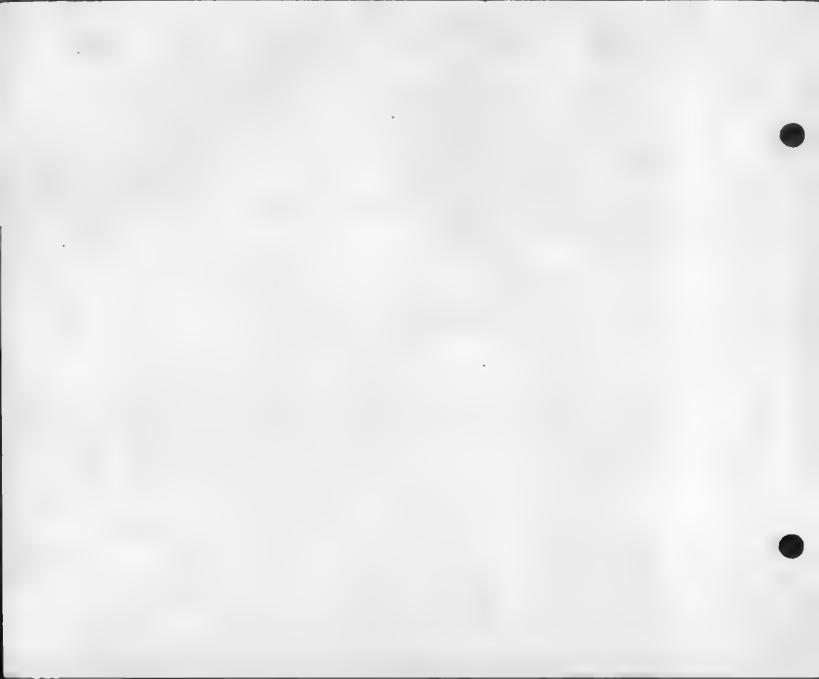


MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH 0 and 2 death, 24 haurs after death 2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) PLACE OF DEATH o COUNTY b. COUNTY Carroll Carroll MARYLAND c CITY OR TOWN (If outside corporate limits, write RuRAL and give nearest town) CLENGTH DE STAY IN b b CITY DR TOWN of suitade corpo ofe Imits, write RURAL and give nearest town Rural) Sykesville. Maryland (Rural) Sykesville 10m 41v filled in I d NAME OF HOSP TAL DR INST. UTION, If not in hosp to, give street oddress) d STREET ADDRESS IS RESIDENCE No address given at time of Springfield State Hospital YES ND DC within admission carban 3 NAME OF F rs+ Midale «gmprétely James DECEASED Pusek 66 19 DEATH (Type or part) expended IF JADER 24 HRS S SEX 6 COLOR OR RACE 7 MARRIED NEVER MARR ED 8 DATE OF BIRTH 9 AGE (r veors remave o glasto rthdoy) unknown-gave Hours white male in any WIDOWED D VORCED physician and 100 USUAL OCCUPATION Give kind of work done 10b KIND OF BUS NESS OR 12 CUSZEN OF WHAT 11 BIRTHPLACE County & Stote or foreign country) INDUSTRY CDLNTRY? please during most of working life, even if refired) andi unknown requires that the death certificate 13 FATHER'S NAME 14. MOTHER'S MAIDEN NAME remayal. attending phys unknown unknown IS WAS DECEASED EVER IN . S ARMED FORCES? 17 INFORMANT Address 16 SDC AL SECURITY NO permit. (Yes, no, or unknown) (If yes give wor or dates of service) - D Hospital Records signed by the attent burial-transit permit burial, cremation, a 220-54-7419 unknown NIERVAL BETWEEN 18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).) ONSET AND DEATH PART I DEATH WAS CAUSED BY-.MMEDIATE CAUSE (o) DHE TO east disease Conditions if any which gave rise to immediate couse (a), DUE TO os the prior to b stating the underlying couse attending has been PART II OTHER S GNIFICANT CONDUTIONS CONTR. TING TO DEATH BUT NOT RELATED TO THE TERM NAL DISEASE CONDITION GIVEN IN PART I(o) WAS AUTD PSY PERFORMED? for use Health NO K Page 4 may be refained by the haspital or O FUNERAL DIRECTOR: After this certificate director, page 3 shauld be detached for us shauld be filed with the State Dept, of Healt ATTENDING PHYSICIAN: 200. ACCIDENT WAS UNDERLYING OF CONTRIBUTING CAUSE OF DEATH 205 DESCR BE HOW INJURY OCCURRED (Enter noture of injury in Port 1 or Port # or per 18.) CERTIF (IF EITHER, NOTIFY MEDICAL EXAMINER) MEDICAL 20e PLACE OF NJURY (Home, form, 20c TIME OF INJURY Month Doy Year 20d IN, JRY OCCURRED 20f (City or town) (County) (Stote) Hour o.m. factory, street, office bldg., etc.) ot work at work deceased from 11-13 , 19-24 , to 9-13 , 19-66 that (i) (we) last 19-66 , and that death accurred at 5-12-M, from couses and on the date stated above. 19.66 that (we) last 21. I certify that # (this haspital) attended the deceased from _ saw the deceased alive on. 276 DATE SIGNED 220 S GNATURE 9-13-66 DIRECTOR PHYS. 22d ADDRESS Sykesville. Maryland 22c PHYSICIAN'S NAME (Type) Springfield State Hospital NAME OF CEMETERY OR CREMATORY 23d LOCATION (City or Town) (Stote) BURIAL, CREMATION, DATE THEREOF (County) REMOVAL (Schedity) 256 REGISTRAR'S 5 GNATURE ADDRESS 250 REC D BY REGISTRAR 24. FUNERAL D RECTOR VR A15 (4) C 20 M 1/66 ED 0 0





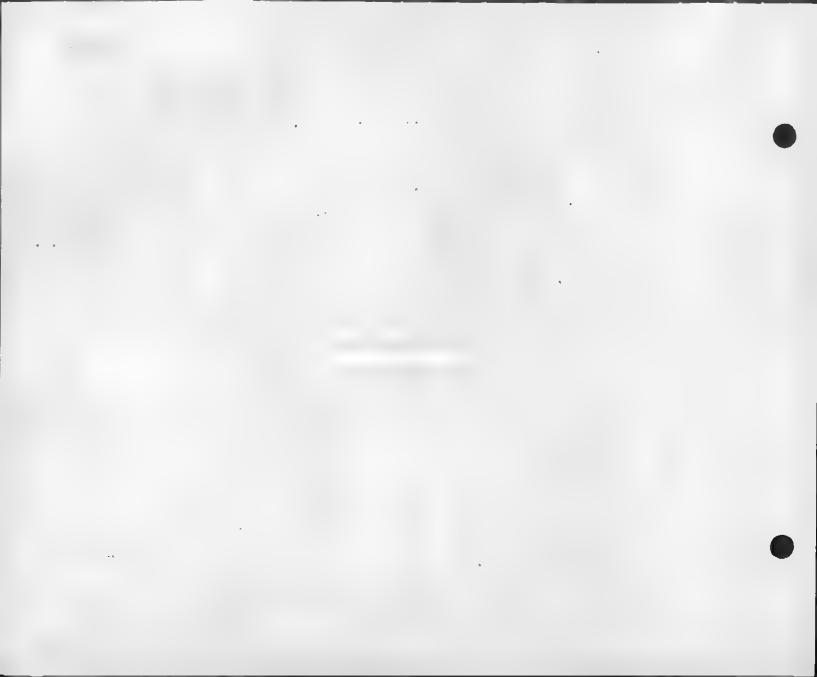
MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND MEDICAL EXAMINER'S CERTIFICATE OF 1. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before ad lission) a. COUNTY b. COUNTY Carroll b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) MARYLAND c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) lay is necessarily to the funeral Page 5 may b C. LENGTH OF STAY IN 16 Union Bridge. Maryland Sykesville d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d, STREET ADDRESS e. IS RES DENCE ON A FARM? YES NO Springfield State Hospital 3. NAME OF Middle DATE Year **DECEASED** (Type or print) DEATH September 22, Blanche Rippeon AGE (In years IFUNDER 1 YEAR IIFUNDER 24 HRS. 6. COLOR OR RACE DATE OF BIRTH 7. MARRIED NEVER MARRIED birthday) | Months | Days Hours WIDOWED * 25/1900 DIVORCED white 10a USUAL OCCUPATION, Give kind of work done | 10b. KIND OF BUSINESS OR BIRTHPLACE (State or foreign country) 12. CITIZEN OF WHA during most of working life, even if retired) INDUSTRY COUNTRY? U.S.A. Maryland Housewife Men E 14. MOTHER'S MAIDEN NAME Nettie Virginia Routson Harvey Clayton Bloom
15. WAS CECEASED EVER IN U. S. ARMED FORCES? File 16. SOCIAL SECURITY NO. INFORMANT (Yes. no. or unkown) (If yes pire war or dates of service) removal. 220-54-6920 hospital history no 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).] INTERVAL BETWEEN ONSET AND DEATH PART I. DEATH WAS CAUSED BY: Acute John mr John In Hours IMMEDIATE CAUSE (a) DUE TO Arteriosclerotic heart disease Veamo Conditions, If any, which (b) gave rise to immediate DIJE TO cause (a), stating the underlying cause last. (C) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 119. WAS AUTOPSY PERFORMED? CERTIFICAT YES [X] NO 20a. EXTERNAL CAUSE WAS DESCRIBE HOW INJURY OCCURRED, (Enter nature of Injury In Part 1 or Part 1) of Item 18.) PRIMARY TO OF CONTRIBUTING T PE CAUSE OF DEATH. 3 shou 20c. TIME OF INJURY Month, Day, Year, 20d. INJURY OCCURRED | 20e. PLACE OF INJURY (Home, farm,) 20f. (City or town) (County) factory, street, office bldg., etc.) Hour a.m. Not While at work at work 21. I certify that I took charge of the remains described above, held an Autopsy \(\sqrt{\chi} \) Inspection Inquiry and in my opinion the cert should Hamicide Undetermined manner death resulted from: Natural causes Accident Suicide DIRECT CHIEF MEDICAL EXAMINER Your execute Page 22. DATE SIGNA ASSISTANT MEDICAL EXAMINER SIGNATURE for FUNERAL f Health or **EXAMINER'S** retained director. NAME (Type NAME OF CEMETERY OR CREMATORY LOCATION (City, town or county) BURIAL, CREMA ADDRESS REC'D BY REGISTRAR VR A15ME 350D 4-64



Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH 2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) PLACE OF DEATH b COUNTY Carroll o (Outarroll) MARYLAND executed within 24 hours after E LENGTH OF STAY IN 16 c CITY OR TOWN (If outside corporate mits write RURAL and give nearest town) b CITY OR TOWN (If outside corporate im ts, write RURAL and give necrest fown) 4 yr., 3 mon. Sykesville 8 dys. New Windsor I campletely filled in binave carban papers ny event, within 72 hai S RESIDENCE ON A FARM? d NAME OF ROSPITAL OR INSTITUTION (If not in hospital give street oddress) d. STREET ADDRESS YES 🗶 NO Springfield State Hospital 4 DATE 3 NAME OF Lost Year DECEASED OF DEATH September 19 66 (Type or pant) Raymond Rumsport 1 8 DATE OF B.RTH 1 3-1857 AGE 'n years FUNDER I YEAR FUNDER 24 HRS Male 7 MARRIED NEVER MARR ED e attending, physic an and cam permit. Then please remave lost bythdoy 10-17-1889 W DOWED TO D VORCED 1Do JSUAL CCCUPATION Give kind of work done 10b K ND OF BUSINESS OR 13 B RTHPLACE 'County & State or foreign country) 12 CITIZEN OF WHAT death rentylicate be COUNTRY U.S.A. during most of working the even if retired)

Sawmill _NDUSJRY Maryland Lumber 13 FATHER'S NAME 14 MOTHER'S MAIDEN NAME Unicom LAVENIA PICKETT William A. Rumsport IS WAS DECEASED EVER IN U.S. ARMED FORCES? 16 SOCA, SECURITY NO 17 INFORMANT Yes no, or unknown) (If yes give wor or dotes of service) 215-10-5408 Records, Springfield State Hospital s gned by the attention of transit permit burial, cremation, a 18 CAUSE OF DEATH (Enter only one cause per line for (a) (b) and (c)) NTERVAL BETWEEN ONSEL AND DEATH PART I DEATH WAS CAUSED BY Arteransclerotic cardinvascular desease IMMEDIATE CAUSE (o)_ Generalized arteriosclerosis Conditions, if any which gove years rise to immediate couse (a) DUE TO has been s ise as the b th priar tab stating the under ying couse months Infected decubitus ulcers PART .I. OTHER S.GNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION G VEN IN PART 1(o) 19 WAS AUTOPSY PERFORMED? NO certificate 200 ACCIDENT WAS UNDERLYING 20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part or Part 1 of .tem 18.) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20d INJURY OCCURRED 20e PLACE OF INJURY (Home, farm, (City or town) (County) (Stote) 20c TME OF NJURY Month, Day, Year for FUNERAL DIRECTOR: After this director, page 3 should be detacted should be filed with the State Dep Haur om. factory, street, office bldg, etc.) Not While 21 I certify that (I) (this hospital) attended the deceased from 5-16-162 9-3 , 19.66, that (1) (we) last 1966, and that death accurred at 3:30PM, from causes and on the date stated above saw the deceased alive an 9-3 22b. DATE SIGNED 9-3-1966 Octavio A. Ruiz 22c PHYSIC ANS 22d ADDRESS NAME (Type) DE Springfield State Hospital 230 BURIAL CREMATION 23b. DATE THEREOF 23d LOCAT ON (City or Town) (County) REMIDVAL (Specify) BETHEL RURAL 24 PUNERAY DIRECTOR VR A15 (4) 20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH



TO FUNDEAL DIRICTOR: After This mertificate has been migned by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 4 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours affer death. TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

			MARYLAND STATE D	EPARTMENT .	OF HEALTH	
	DIVISION OF	F STATISTICAL	RESEARCH AND RECORD	S. 301 W. PRES	TON STREET.	BALTIMORE 1, MARYLAND
-1	2515		CERTIFICAT			12610
224						- 170111

1.	PLACE DF DEATH a COUNTY MARYLANO	2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE b. COUNTY			
1	b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Sike apillo	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			
	d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)	d. STREET AOORESS 0. IS RES DENCE ON A FARM? YES NO X			
3	NAME OF First Middle DECEASED (Type or print)	Last 4. DATE Month Oay Year OF OEATH 19			
	WIOOWEO Z DIVORCEO	8. OATE OF BIRTH 9. AGE (In years IFUNOER1 YEAR IFUNDER 24 HRS. Months Days Hours Min. yrs.			
du	a. USUAL OCCUPATION (Give kind of work done ring most of working life, even if retired) 10b. Kind of Business or INOUSTRY	11. BIRTHPLAGE (County & State, or foreign country) 12. CITIZEN OF WHAT COUNTRY?			
	FATHER'S NAME	14. MOTHER'S MAJOEN NAME			
15 (Y)	es, no, or unkown) (If yes give war or dates of service)	INFORMANT Address			
L CERTIFICATION	20a. ACCIDENT WAS UNDERLYING CONCRIBE HOW INJURY OCCUP OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	Leiral tremanchage interval Between onset and Death of a Cardio was accorded disco 11 2/22			
MEDICAL	20c. TIME OF INJURY Month, Oay, Year 20d. INJURY OCCURRED 20e. PLAC Factor 20d. INJURY OCCURRED 20e. PLAC Factor 20d. INJURY OCCURRED 20e. PLAC Factor 20d. INJURY OCCURRED 20e. PLAC 20d. INJURY OCCURRED 20d	CE OF INJURY (Home, farm, 20f. (City or town) (County) (State) ry, street, office bldg., etc.)			
232	21. I detail that to this hospital attended the deceased from 2	22d. ADORESS Syke Sville, Ad.			
24	FUNERAL DIRECTOR ADDRESS	252. REC'D BY REGISTRAR 250 REGISTRARS & GNATURE OATE SEP 1 1 1966 Floreles Judge			

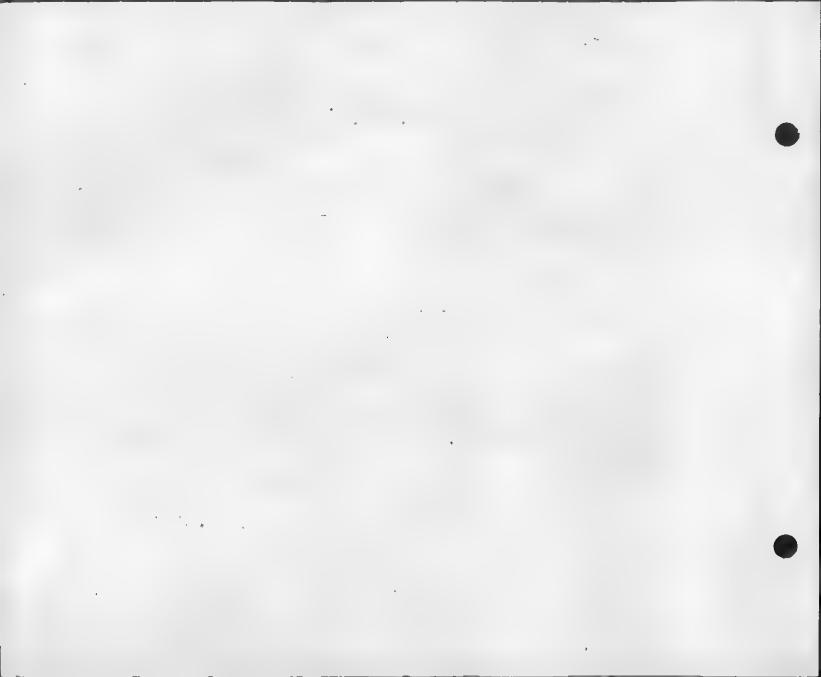
VR A15 (4) 20M 1/65



MARYLAND STATE DEPARTMENT OF HEALTH 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND DIVISION OF STATISTICAL RESEARCH AND RECORDS. CERTIFICATE OF DEATH funeral 2. USUAL RESIDENCE (Whate decaasad lived, If institution: Residence before admission, 1. PLACE OF DEATH b. COUNTY Carroll a. COUNTY by the and 2 death, Carrol. Marvland MARYLAND b. CITY OR TOWN (if outside corporate limits, c. LENGTH OF STAY IN 16 c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) write RURAL and give nearest town) after .5 7 Pages Rural Tanevtown Rural Tanevtown filled d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) d. STREET ADDRESS . IS RESIDENCE ON A FARM? P.O. Route # completely P.O. Route # papers. YES NO TY 3. NAME OF 72 Middle 1 a ct 4. DATE Month Day Year DECEASED OF (Type or print DEATH Lester Shifler Lerov Sentember 19 66 and cor with S. SEX 6. COLOR OR RACE 9. AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS. 8. DATE OF BIRTH 7, MARRIED TO NEVER MARRIED last birthday) | Months Lale White certificate WIDOWED F DIVORCED [March 26. physician rempve 10a. USUAL OCCUPATION (Give kind of work 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (County & State, or foreign country, 12. CITIZEN OF WHAT COUNTRY! done during most of working life, avan if retired) Power Company Electrician Marvland 13. FATHER'S NAME 1 14. MOTHER'S MAIDEN NAME din de Orville E. Shifler Barbara Sensenbaugh Then removal, 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT Address R # 2 [Yas, no, or unknown (Ifyasgivawarordatesofservica) Frs. L. Leroy Shifler Taneytown, arvland 18. CAUSE OF DEATH |Finter only one cause per line for (e), (b), and (c). INTERVAL BETWEEN varial-transit per ONSET AND DEATH IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gava rise to immediata cause 五 (a), stating the undarlying 节型 cause last. PART II. OTHER S GNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT 5 CERTIFICATION ospita PERFORMED? schod for use Health prior NO 🔀 20a. ACCIDENT WAS UNDERLYING (1) 20b. DESCRIBE HOW INJURY OCCURRED. (Entar nature of injury in Part I or Part it of Item 18.) OR CONTRIBUTING [] CAUSE OF DEATH detached (IF EITHER, NOTIFY MEDICAL EXAMINER) After 20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED | 20e. PLACE OF INJURY (Home, farm, † 20f. (City or town) (County) (State) Ö factory, streat, office bldg., etc.) Whila Not While ä Dept. at work at work p.m. CTOH 21. I certify that (I) (this hospital) attended the deceased from . 32.01. 10.50 FT -1 19.66 that (I) (+++) last HE 19 M, from the causes and on the date stated above. saw the deceased alive on ... ? ? ... 22a SIGNATUR 22b. DATE ATTENDING MATO FUNERAL ector, page DIRECTOR PHYS. PHYS, HOSPITA 22c. PHYSICIAN'S 22d. ADDRESS NAME (Typa) filed v Ambler Thompson Frederick St. Tarevtown, maryland 23c. NAME OF CEMETERY OR CREMATORY 23a, BURIAL, CREMATION, 23b. DATE THEREOF 23d. LOCATION (City, town or county) (State) 0.58 9 REMOVAL (Specify) Kevsville Cemeterv Keysville, Carroll Co... 24 FUNERAL DIRECTOR'S SIGNATURE 25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE Taneytown, Mid. DATE SEP 1956 Jolianles Judge VR A15 (4) 20M 5-63



MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH 24 havrs after death 2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission I PLACE OF DEATH a. COUNTY **b** COUNTY Carroll Maryland MARYLAND campletely filled in by the fu ave carban papers Pages I A event, within (2 hoors often CLTY OR TOWN (f autside carparate limits, write RURAL and give nearest town) CLENGTH OF STAY b CITY OR TOWN ! floutside carporate limits, Sykesville mo. Baltimore 21231 B IS RES DENCE ON A FARM? d NAME OF HOSPITAL OR INSTITUTION (I nation haspital give street address) d STREET ADDRESS Springfield State Hospital 1928 Aliceanna YES NO S executed within campletely fi First Sklodovski 4. DATE 3 NAME OF Middle Manth Day Year (Type or post) MMN Anthony SKLADOSKI September 19 66 GEATH 8 DATE OF BIRTH 9 AGE In years IF FINDER YEAR 6 COLOR OR RACE 7 MARR EO NEVER MARRED Haurs birthday) Months Days lease remay 9-29-1896 white WIDOWED DIVORCED male gug 12 CT.ZEN OF WHAT 10a USUAL OCCUPATION (Give kind of wark done 10b KINO OF BUS NESS OR 11 BIRTHPLACE (County & State or foreign country) COUNTRY? during more of work gille, even if retired)
Stevedore Longshorman physician (Poland the death cert fcate Poland 13 FATHER'S NAME 14 MOTHER'S MAIDEN NAME ar remaval, Alec Skladoski *Sklodowski Mary Gonsocki (Gaska 15 WAS DECEASED EVER IN U.S. ARMED FORCES? 16 SOCIAL SECURITY NO 17 INFORMANT permit. (Yes, no. ar unknown) I(If yes give war ar dates of service) 217-01-2008 Springfield State Hospital Records signed by the after burial-transit perm burial, cremation, a 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) INTERVAL BETWEEN ONSET AND DEATH PART I DEATH WAS CAUSED BY Cardiac failure. reguires that IMMEDIATE CAUSE (a) by the haspital ar attending physician DUE TO Pulmonary tuberculesis. Conditions flany, which gave vears rise ta immediate couse (a), OLE TO has been s ise as the t th priar ta b stating the underlying cause 19 WAS ALTOPSY PART I OTHER SIGNIFICANT CONDITIONS CONTRIBLYING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) PERFORMED? CBS assoc. with circulatory distrubance, with cerebral arterioscleros with psychotic reaction. be detached far use State Dept. of Health TO FUNERAL DIRECTOR: After this certificate director, page 3 should be detached for us should be filed with the State Dept. of Healt 205 DESCRIBE HOW INJURY OCCURRED (Enter nature of mony in Part I or Part I of item 18) 20g ACCIDENT WAS UNDERLYING [OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20e PLACE OF NJURY (Hame, farm, 20d NJURY OCCURRED (City or town) (County) (State) 20c TIME OF INJURY Month, Day, Year factory, street, affice bldq, etc.) Haur am. Nat While al work 21 1 certify that (1) (this hospital) attended the deceased from -8-2-55 19___, that () (we) last , and that death accurred at 2:05 M, from causes and an the date stated above. be retained -25-56 saw the deceased alive an 22b DATE SIGNED 22d SIGNATURE ATTENDING MIK PHYS Springfield State Hospital 22d ADDRESS 22c PHYSICIAN S NAME (Type) N. Buyukunsal, M.D Naci Sykesville, Maryland 21784 23b DATE THEREOF 23c NAME OF CEMETERY OR CREMATORY 23d LOCATION (City or Town) (County) 23a BUR AL, CREMAT ON (State) REMOVAL (Specify) Holy Rosary Cemetery Baltimore Marv.land 24 ENERAL DIRECTOR GEOTIFE A. Weber 705 South Ann Street 256 REGISTRAR'S SIGNATURE 250 REC D BY REGISTRAR with your year of VR A15 (4) 20 M 1/66



MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND FOR STATE MEDICAL EXAMINER'S CERTIFICATE OF DEATH HEALTH DEPTS USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) 1. PLACE OF DEATH a. COUNTY b. COUNTY Maryland Carroll Baltimore City aelay is necessary, and 3 to the funeral 3. Page 5 may be b. CITY OR TOWN (If outside corporate limits, c. CITY OR TOWN (If outside corporate limits, write RURAL and give neafest town) C LENGTH OF STAY IN 1b write RURAL and give nearest town) Baltimore Svkesville d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d. STREET ADDRESS e. IS RESIDENCE ON A FARM? State Springfield State Hospital Greenmount Avenue YES NO I N 2, and PM3. DATE 3. NAME DE Middle Last the 72 OECEASED ßF ELOISE (Type or print) DEATH September 6. COLOR OR RACE 8. OATE OF BIRTH 9. AGE (In years | IF UNDER 1 YEAR IF UNDER 24 HRS 7. MARRIED NEVER MARRIEO last birthday) Months | Oays Hours Female WIDOWED Sep.O.VORCEO 10a. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR during most of working life, even if retired) | INOUSTRY 11. BIRTHPLACE (State or foreign country) 12. CITIZEN OF WHAT COUNTRY? Waitress Georgia II.S.A aft 13. FATHER'S NAME 14. MOTHER'S MAJOEN NAME Ade Walker Marie Davis 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) [(If yes give war or dates of service) 16. SOCIAL SECURITY NO. " in pencil ir Examiner's No Unknown Records, Springfield State Hospital 18. CAUSE DF DEATH [Enter only one cause per line for (a), (b), and (c),] INTERVAL BETWEEN ONSET AND DEATH PART I. OEATH WAS CAUSED BY: burial-transit cremation, or Bilateral interstitial bronchepneumonia, probably IMMEDIATE CAUSE (a). aspiration type **DUE TO** Conditions, if any, which (b) gave rise to immediate **OUE TO** cause (a), stating the the word ' LC) underlying cause last. (c) PART II OTHER SIGNIFICANT CONCIT. ONS CONTRIBLING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS AUTOPSY WITH CONVULSIVE GISOTOET, WITH PSYCHOLIC TERCTION. YES T alcohol intoxication, with psychotic reaction.

CAUSE WAS | 20b. DESCRIBE HOW !NJURT OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) ND 20a. EXTERNAL CAUSE WAS PRIMARY OF CONTRIBUTING CAUSE OF DEATH. 필급 3 shou MEDICAL 20d. INJURY OCCURRED | 20e PLACE OF INJURY (Home, farm, | 20f. (City or town) 20c. TIME OF INJURY Month, Oay, Year (County) (State) factory, street, office bldg., etc.) Hour a.m. Not While be CTOR: Page designated at work at work the cert 21. I certify that I took charge of the remains described above, held an Autopsy Xi, Inspection . Inquiry . and in my opinion Undetermined manner death resulted from: . Natural causes Accident Suicide Apmicide your Sute Page DATE SIGNED SIGNATURE director, Pag retained for FUNERAL I EXAMINER'S / NAME Type W. Glenn Sporcher, 23a, BURIAL, CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY LOCATION (City, town or county) 0 REGISTRAR'S SIGNATURE FUNERAL-DIRECTOR VR A15ME 35D0 4-64



1, 1	2001CH	ERTIFICATI		1	2614		
4	PLACE OF DEATH COUNTY		a. STATE	Where deceased lived, If institute b. COUNTY	fion: Residence before a		
	Carroll	MARYLAND	Md.				
	c. CITY OR TOWN (if autside corporate limits, write RURAL and give nearest town)	TH OF STAY IN 16	c. CITY OR TOWN (If ou	tside corporate limits, write RURA	AL and give nearest tow		
	Sykesville		Baltimore	21234	-35 - of		
	I. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give	street address)	d. STREET ADDRESS		e. IS RE		
^	Route 4 Box 165A Sykesville		2303 Pentla	and Drive	YES		
	NAME OF DECEASED Type or print) Vet Non	Middle	ydinoe	DATE Month OF DEATH	Day Year 24 196		
5.	SEX 6. COLOR OR RACE 7. MARRIED NEV	ER MARRIED B.	DATE OF BIRTH		DER TYEAR IF UNDER		
	WOODWED T	DIVORCED T	11/24/1896	last birthday Mon	ths Days Hours		
10a	USUAL OCCUPATION (Give kind of work 10b. KIND OF BL	SINESS OR INDUSTRY			CITIZEN OF WHAT C		
-	etired Supt. Ship Bl	de.	Baltimore,	24.2	U.S.A.		
	FATHER'S NAME		14. MOTHER'S MAIDEN NAM				
	Basil S. Tydings		Julia M. Tuho	olka			
	WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL S	ECURITY NO. 17. IN			t.412-21234		
(Ye	No (Ifyes give war or dates of service)	-7156 Mr	rs. Julia M. 1	Tydings 2303 Pe			
	1B. CAUSE OF DEATH [Enter only one cause per line for (a).		1		INTERVAL BET		
	PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	naky 1	2 Cluse	cer	ONSET AND		
	DUE TO DO 1 1 TO 11 OD 11						
	Conditions, if any, which \ (b) Haler	of derof	ie wallo	Varadio de	sease 8 5		
	gave rise to immediate cause	1			0		
	(a), stating the underlying cause last.	Henry In	ar .		8 2		
-	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING	TO DEATH BUT NOT	RELATED TO THE TERMINAL	DISEASE CONDITION GIVEN IN	PART 1(a) 19. WAS A		
ő	Anemy	Hector	es		YES T		
ATION				t I or Part II of item 18.)			
TIFICATION	208. ACCIDENT WAS UNDERLYING 1 206. DESCRIBE FO	W INJURY OCCURRED.	(cases nature of injury in Par	I do t day is not have seed			
CERTIFICATION	200. ACCIDENT WAS UNDERLYING 1 206. DESCRIBE FOO OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	W INJURY OCCURRED.	(teres nature of injury in Far				
- 4	OR CONTRIBUTING CAUSE OF BEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY Month, Day, Year 2Dd. INJURY OF	CCURRED 200. PLACE	E OF INJURY (Home, farm,	20f. (City or town)	(County) (
MEDICAL CERTIFICATION	OR CONTRIBUTING CAUSE OF BEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY Month, Day, Year Hour a.m. While Not Year	CCURRED 200. PLACE			(County) (
- 6	OR CONTRIBUTING CAUSE OF BEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY Month, Day, Year Hour a.m. 2Dd. INJURY O While Not a	CCURRED 20e. PLACE factory	E OF INJURY (Home, farm,	20f. (City or town)	(County) (
- 6	OR CONTRIBUTING CAUSE OF BEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 21. I certify that (I) (this hospital) attended the	CCURRED 200. PLACE fectory work deceased from	E OF INJURY (Home, form, y, street, office bldg., etc.)	20f. (City or town)	, 1966, that (I) (s		
- 6	OR CONTRIBUTING CAUSE OF BEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 21. I certify that (I) (this hospital) attended the	CCURRED 20e. PLACE factory	eath occurred at A	20f. (City or town)	, 1966, that (I) (s		
	OR CONTRIBUTING CAUSE OF BEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY Month, Day, Year While at work 19 at work	CCURRED 200. PLACE fectory work deceased from	eath occurred at A. ATTENDING MED.	204. (City or town) 2.4. to Seff. A. 4. Why, from the causes and compared to the causes and compared to the causes.	, 19 (a), that (I) (son the date stated		
	OR CONTRIBUTING CAUSE OF BEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY Month, Day, Year While at work 19 at work	CCURRED 200. PLACE While fectors work deceased from deceas	eath occurred at A. ATTENDING MED.	204. (City or town) 2.4. to Seff. A. 4. Why, from the causes and compared to the causes and compared to the causes.	, 19 (a), that (I) (son the date stated		
-6	OR CONTRIBUTING CAUSE OF BEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY Month, Day, Year While at work 19 at work	CCURRED 200. PLACE While fectors work deceased from deceas	eath occurred at ATENDING MED. ATENDING MED. DIRECT	204. (City or town) 2.4. to Seff. A. 4. Why, from the causes and compared to the causes and compared to the causes.	, 19 (a), that (I) (son the date stated		
MEDICAL	OR CONTRIBUTING CAUSE OF BEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY Month, Day, Year While at work 19 at work	CCURRED 200. PLACE While fectors work deceased from deceas	eath occurred at ATTENDING MED. PHYS. 22d. ADDRESS	204. (City or town) 2.4. to Seff. A. 4. Why, from the causes and compared to the causes and compared to the causes.	, 19 (a), that (I) (son the date stated		
MEDICAL	OR CONTRIBUTING CAUSE OF BEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY Month, Day, Year While Not yellow at more at a work 19 at work 1	deceased from M.D.	eath occurred at AI ATTENDING MED. PHYS. DIRECT	20f. (City or town) Out to (Lef. 14.) My, from the causes and company of the causes and cause	on the date stated 22b. 24 6 (Shownty) (Shownty)		
MEDICAL	OR CONTRIBUTING CAUSE OF BEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY Month, Day, Year While Not Year at work at w	deceased from	eath occurred at ATENDING MED. ATTENDING MED. PHYS. DIRECT	20f. (City or town) 2. to f.	on the date stated 22b. 24 6 (St		

em 1790

17.50

29/29

Transite A bretter

MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH ond 2 executed within 24 hours after death 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) PLACE OF DEATH Allegany o. COUNTY Carroll by the f Pages c. CITY OR TOWN (If autside carparate limits, write RURAL and give nearest town) E LENGTH OF STAY IN 16 b CITY OR TOWN (If autside carporate limits, and completely filled in by the eremove carbon papers. Page in any event within 72 hours o write RURAL and give nearest town) 2yrs.3mos.17dys. Cumberland Sykesville d. NAME OF HOSPITAL OR INSTITUTION (If not in haspital, give street address) d. STREET ADDRESS e. IS RESIDENCE ON A FARM? Springfield State Hospital 503 Decatur St. NO DE Middle DATE 3 NAME OF Month Last OF DEATH DECEASED SEPTEMBER JOHN. ALVIN WAGNER 66 (Type or print) IF UNDER 1 YEAR IF UNDER 24 HRS B. DATE OF BIRTH AGE (In years SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED Jost birthday) Hours 3-19-1882 White Male WIDOWED DIVORCED 12. CITIZEN OF WHAT 10a. USUAL OCCUPATION (Give kind of work done 11 BIRTHPLACE (County & State, or fareign country) during most of warking the, even if retired) U.S.A. ease INDUSTRY Maryland the deoth certificate 14 MOTHER'S MAIDEN NAME 0 or removal. en Amanda Barth Millard Fillmore Wagner ottending p 17. INFORMANT 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO Address (Yes, na, grunknawn) (If yes give war or dates af service) 211-10-5113 Records, Springfield State Hospital cremotion, INTERVAL BETWEEN IB. CAUSE OF DEATH (Enter only one cause per line far (a), (b), and (c).) signed by the burial-transit p the Months PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Carcinoma of the rectum with metastasis to liver requires that ottending physician. DUE TO Conditions, if any, which gave rise to immediate cause (a). DUE TO stating the underlying cause as the hos been (a) Bronchopneumonia Days PART II, OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o) WAS AUTOPSY Chronic brain syndrome assoc. with cerebral arteriosclerosis, with psychotic reaction PERFORMED? TO FUNERAL DIRECTOR: After this certificate had director, page 3 should be detached for use should be filed with the State Dept. of Health YES X NO 205. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20g. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Hame, farm, (City ar town) (County) (State) 20c. TIME OF INJURY Month, Day, Year factory, street, office bldg., etc.) Hour a.m. Not While ATTENDING at work at work 21. I certify that (I) (this hospital) attended the deceased from 6-2-51; , to 9-19-66 , 19 , that (1) (we) last . 19 be retained 19 and that deoth occurred of 2012 M, from couses and on the date stated above. saw the deceased alive on 22n SIGNATURE 22b. DATE SIGNED 9-19-66 DIRECTOR 22d. ADDRESSpringfield State Hospital 22c PHYSICIAN'S NAME (Type) Frances Reid Nabors, M. D. Sykesville, Maryland 23d_ LOCATION (City or Town) NAME OF CEMETERY OR CREMATORY (State) 23a. BURIAL CREMATION 23b. DATE THEREO (County) REGISTRAR'S SIGNATURE **ADDRESS** 250. REC'D BY REGISTRAR 24. FUNERAL DIRECTOR Marley 20 M 1/66

21051 THE RESERVE THE PARTY OF THE PA The state of the s building the second second Land or William Darkers are with the Control of the The second contract of the second sec or true acet him to be a FULL STORES AND ROTTERS TO SHALL THE TOTAL THE STREET